Solara

MAR 17 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Dear Administrator:

Solara opposes the harsh reductions in long-term care hospital (LTCH) payments that will result if the proposed changes to the prospective payment system for long-term care hospitals (LTCH PPS) are implemented. Solara agrees with the analysis the Acute Long Term Hospital Association (ALTHA) has made of the proposed rule and found that the Centers for Medicare & Medicaid Services (CMS) used materially flawed and incomplete data in developing their proposed changes to LTCH payments for FY 2007. ALTHA's analysis shows that the assumptions CMS made in developing its proposed changes to LTCH payments for FY 2007 are incorrect due to the data errors discussed in the enclosed documentation, such as using single-year data as the basis for expected norms. We believe that CMS should do the following:

(i) withdraw the proposed rule
(ii) revise the data it is using to develop final payment changes for LTCHs in FY 2007 to correct these data errors
(iii) publish a new proposed rule that will allow for interested and affected parties to provide meaningful comments

We ask that CMS reconsider its proposed changes to the LTCH PPS in light of the Medicare Payment Advisory Commission (MedPAC) recommendations in June 2004 that the certification criteria for the Medicare LTCH provider category be strengthened to ensure that LTCH payments are being made to only those providers that are administering medically complex care to severely ill patients. This approach more clearly defines the method for limiting LTCH payments to those hospitals. Unfortunately, the proposals that CMS advances in this proposed rule use incomplete data and analyses to reach false assumptions about LTCHs and the patients for whom these hospitals care. The proposed payment changes will have a severe impact on all LTCHs and will undoubtedly have a negative impact on quality and available care for LTCH patients. Solara believes that arbitrary payment reductions are the wrong approach if quality of care is to be encouraged.

Sincerely,

Kenneth R. Ross
Chief Executive Officer

Attachments

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March 10, 2006

BY ELECTRONIC FILING AND OVERNIGHT MAIL

Hon. Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
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Baltimore, MD 21244-1850

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

Dear Dr. McClellan:

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

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

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

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

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

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

I. Proposed Changes to Short-Stay Outlier Payments

A. General Description

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

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

B. Assessment

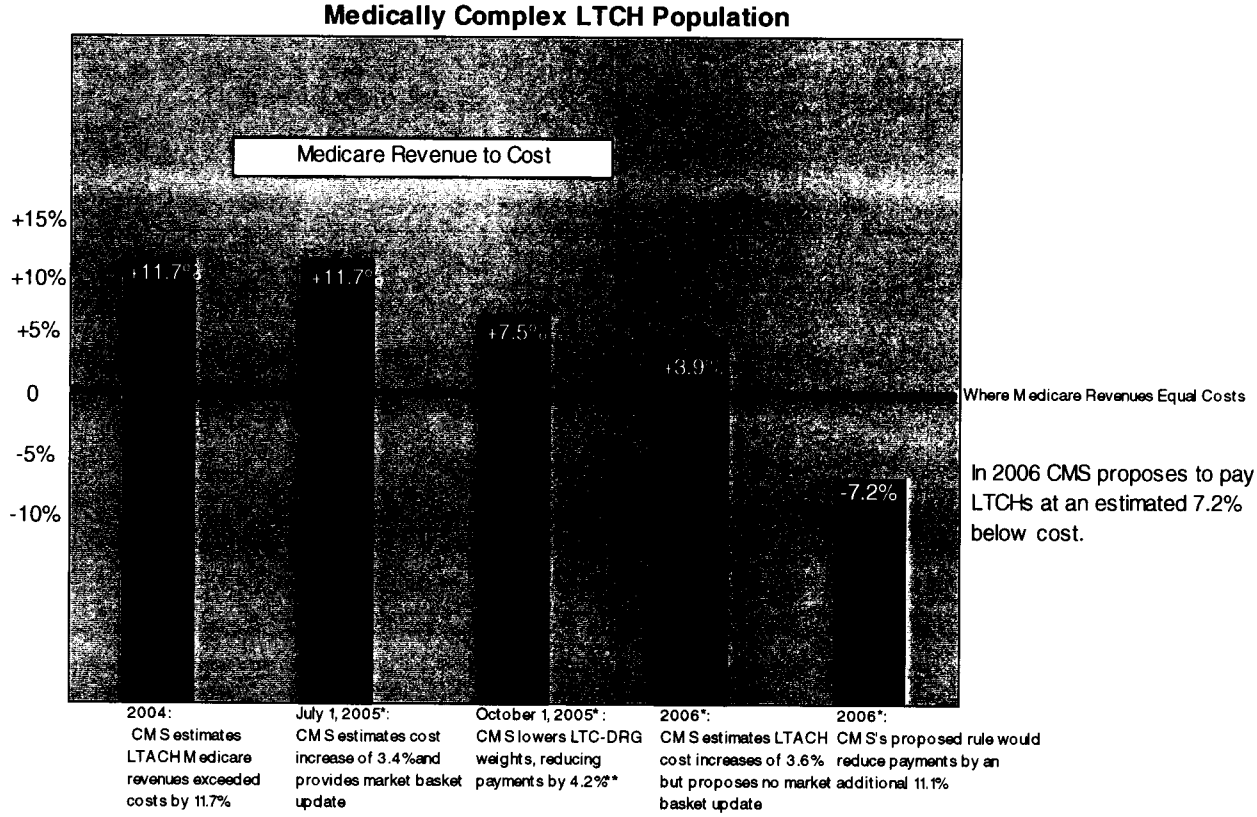
1. CMS's Proposal to Pay for SSO Patients at IPPS Rates Would Result In LTCHs Being Paid Amounts Significantly Below Their Costs of Providing Patient Care

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

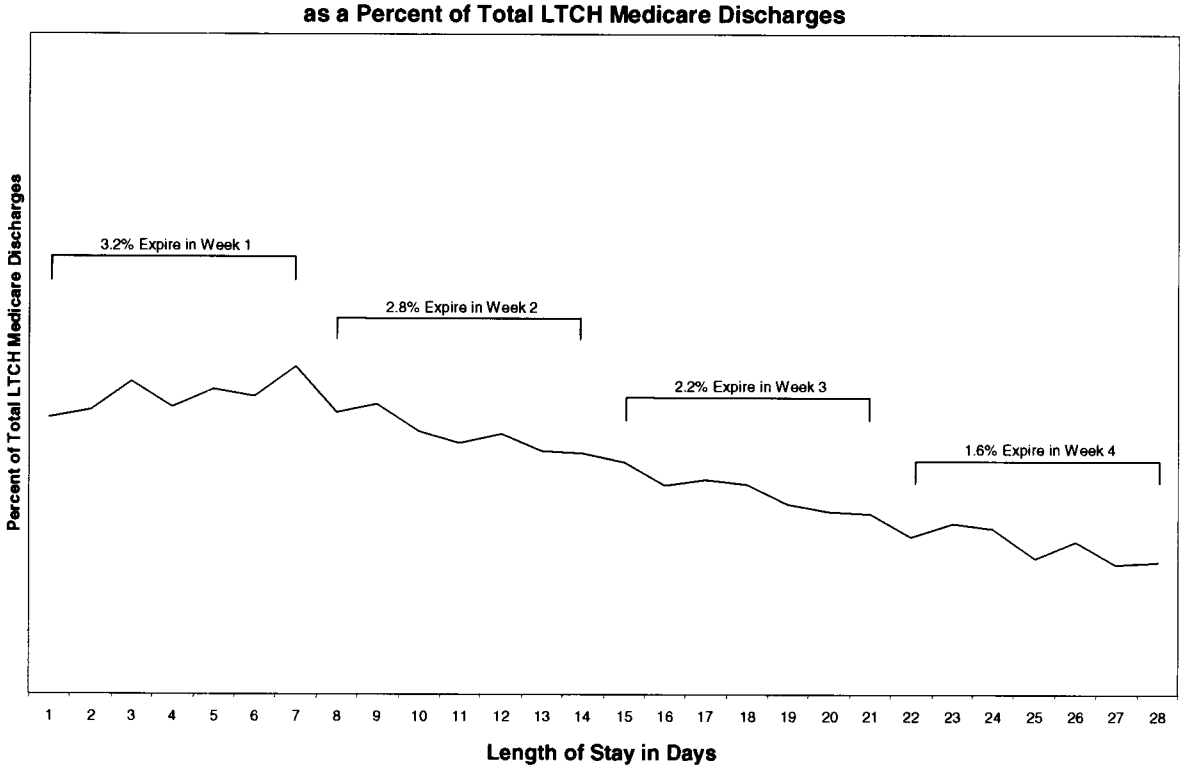
Even if CMS were to find a significant number of SSO cases after most LTCHs had begun to receive payments based in whole or in significant part on the federal rate, CMS would still need to determine from some reliable data source (1) the portion of SSO cases that are patients whose medical condition(s)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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

TABLE 1

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

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

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

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

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

TABLE 2

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

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

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

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

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

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

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

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

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

TABLE 3

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

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

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

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

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

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

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

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

TABLE 4

Comparison of Short-Term, SSO and All LTCH Patients

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Recommendations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

II. Proposal to Not Update the RY 2007 Federal Rate

A. General Description

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

B. Assessment

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

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

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

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

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

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

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

3. The CMS Analysis of LTCH Margins Is Flawed

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

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

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

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

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

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

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

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

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

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

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

C. Recommendations

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

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

III. Monitoring/RTI International Study

A. General Description

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

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

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

B. Assessment

1. Insufficient Description of Methodology to Comment

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

2. Causes of Industry Growth

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

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

3. Patient Outcomes

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

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

4. Descriptions of LTCH Patients

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

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

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

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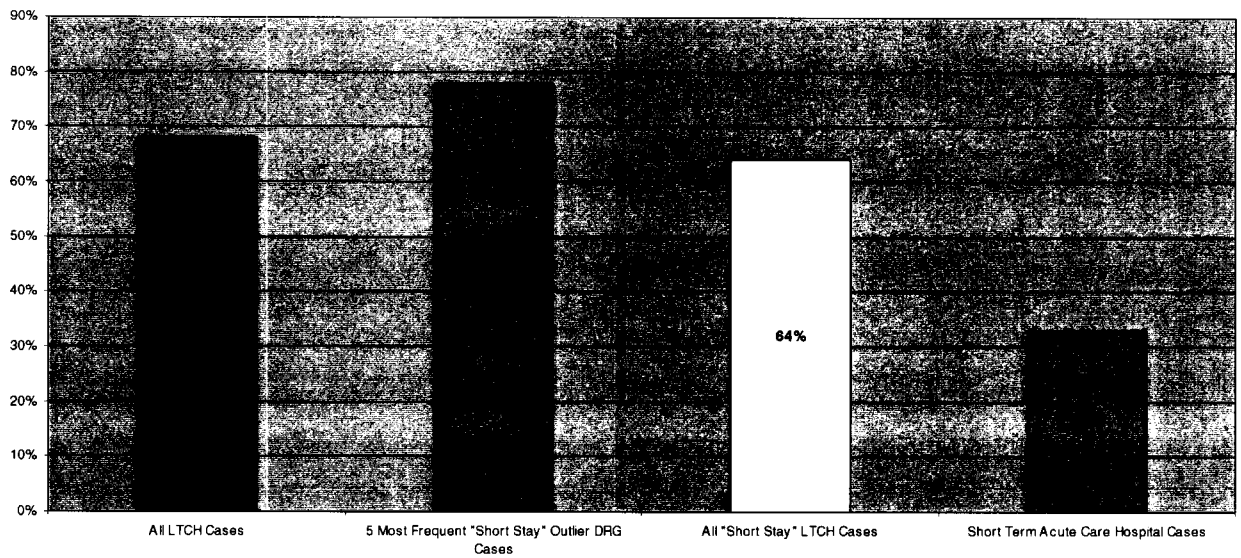
of 3.6%. By reducing the $5.27 billion by the CMS-estimated 11.1% SSO policy effect, and by eliminating the market basket update, spending under existing policies would be $4.5 billion in 2007. CBO estimates of net mandatory Medicare spending in RY 2007 is $383.4 billion, meaning that LTCH spending projections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

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

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

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



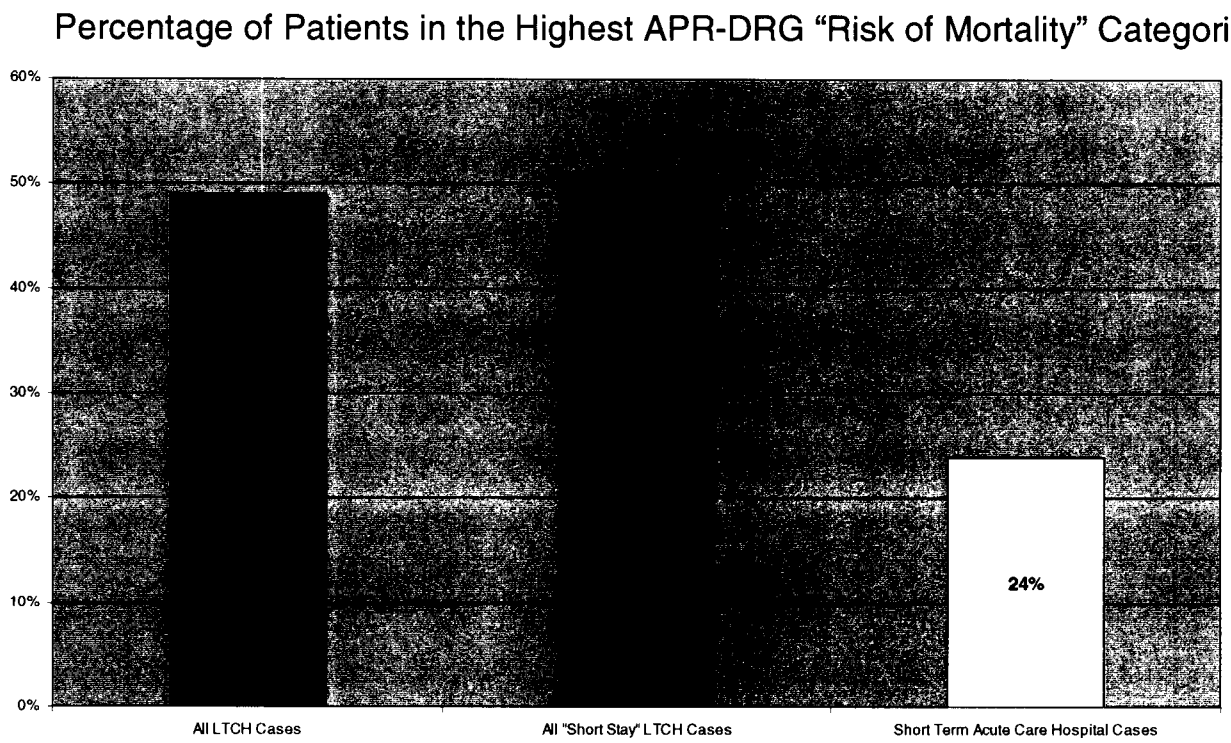
***Source: MedPAR 2004**

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

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

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

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



***Source: MedPAR 2004**

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

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

TABLE 5

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

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

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

C. Recommendations

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

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

A. General Description

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

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

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

B. Assessment

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

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

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

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

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

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

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

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

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

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

C. Recommendations

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

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

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

V. Postponement of One-Time Budget Neutrality Adjustment

A. General Description

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

B. Assessment

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

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

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

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

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

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

C. Recommendations

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

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

A. General Description

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

B. Assessment

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

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

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

C. Recommendations

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

VII. High-Cost Outlier Regression Analysis

A. General Description

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

B. Assessment

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

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

C. Recommendations

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

VIII. SSO Fixed Loss Threshold

A. General Description

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

B. Assessment

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

C. Recommendations

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

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

A. General Description

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

B. Assessment

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

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

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

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

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

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

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

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

C. Recommendation

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

X. CMS Failed to Accurately Complete the Regulatory Impact Statement

A. General Description

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

B. Assessment

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

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

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

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

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

C. Recommendations

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Statistical or actuarial information;

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

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

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

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

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

A. Utility Standard

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

B. Objectivity Standard

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

C. Integrity Standard

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

D. Transparency and Reproducibility Standard

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

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

A. The APA Requires Rulemaking With Meaningful Comments

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

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

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

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

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

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

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

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

B. Correction of Erroneous Information

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

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

C. Public Notice of Correction

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

XIII. Conclusion

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

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

Sincerely,

William Walters
Chief Executive Officer

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

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MAR 20

PARTNERS

By Courier

James J. Mongan, MD
President and Chief Executive Officer
Partners HealthCare System, Inc.

Professor of Health Care Policy
Professor of Social Medicine
Harvard Medical School

An integrated health care system founded by Brigham and Women's Hospital and Massachusetts General Hospital

March 17, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers of Medicare & Medicaid Services
Department of Health & Human Services
Hubert H. Humphrey Building, Room 445-G
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Attention: CMS-1485-P

Dear Dr. McClellan:

Partners HealthCare System, Inc. is pleased to comment on the Prospective Payment System for Long-Term Care Hospitals (LTCHs): RY 2007: Proposed Annual Payment Rate Updates and Policy Changes, and Clarification, Proposed Rule, as published in the January 27, 2006 Federal Register, on behalf of its member Hospitals:

Institution	**Provider Number**
Shaughnessy-Kaplan Rehabilitation Hospital	222026
Spaulding Rehabilitation Hospital	222035

In addition, we are also commenting on behalf of Youville Hospital (Provider Number 222000), with whom we have a partnership.

Overview

Before we begin our comments, we call to CMS attention the comments proposed by the National Association of Long Term Hospitals (NALTH) and the report by the Lewin Group commissioned by NALTH, entitled "Final Report: Analysis of Long Term Care Hospitals RY 2007 Prospective Payment System Notice of Proposed Rulemaking". We incorporate some of NALTH's comments and Lewin's findings in our comments.

Partners HealthCare System, Inc., Prudential Tower, Suite 1150, 800 Boylston Street, Boston, MA 02199-8001
Tel: 617 278-1004, Fax: 617 278-1047, email: jmongan@partners.org

At the outset, we acknowledge the responsibility CMS has to ensure that Medicare is a prudent purchaser of services – in fact, we support CMS' efforts toward this end as our tax dollars fund Medicare. However, CMS has an equally important responsibility to ensure that beneficiaries have access to a stable, secure network of providers delivering quality care seamlessly along the full continuum of care. In proposing the level of payment reductions in this proposed rule, CMS may well be falling short of this responsibility to beneficiaries. The reductions proposed to current payments are unprecedented in any previous proposed rulemaking for any PPS, averaging 11 percent nationwide and 13 percent for New England. With the proposed elimination of the update, these reductions approach 15 percent nationally and 17 percent for New England LTCH providers. According to the Lewin report, these payment reductions will reduce the margins of nonprofit LTCHs to a negative 8.8 percent. Margins this low will undoubtedly threaten the viability of many LTCHs nationwide and the PHS LTCHs as well. ***For PHS LTCH providers, this proposed rule would reduce payments by $7 million a year.***

The impact of these payment reductions on beneficiaries' access to care, we fear, may also be unprecedented. This impact will not only affect LTCHs but "upstream" to acute care hospitals as well. LTCHs are an integral component of the continuum of care, particularly for the long-established providers in the Partners HealthCare System network and many other long-established providers in Massachusetts. Drastically reducing payments for Short Stay Outliers (SSOs) will provide significant disincentives to LTCHs to admit patients likely to become SSOs. Beneficiary stays in acute care hospitals would therefore be extended, delaying or denying them the benefits of the multi-disciplinary care provided by LTCHs. Moreover, because SSOs are difficult to predict, this rule will likely have the "unintended" consequence of delaying or denying long term care for "non-SSO" patients as well.

The impact on capacity-constrained acute hospitals will be direct and harsh: every day of an extended acute hospital stay delays by one day access to that acute bed for a patient, often a Medicare beneficiary, who needs the type of care acute hospitals ***specialize in***, including, of course, surgical procedures not provided for by any other providers. In some cases, this will prevent a patient in an ICU from being discharged to a "routine" bed – in turn, denying access to that ICU bed to patients in need of emergency care and, finally, denying access to emergency services as Emergency Departments go on "Ambulance Divert". Finally, the occurrence of this scenario will only increase as the Baby Boomers enter their elderly years, further constraining the capacity of acute care hospitals.

I. Proposed Update to the Standard Federal Rate for the 2007 LTCH PPS Rate Year

While CMS has "broad authority" under the LTCH PPS enabling statute to withhold an update for 2007, we believe this authority must be used with the utmost caution and only

if unequivocally supported by the data. CMS' proposal to eliminate the market basket update in 2007 is based on the following assumptions:

- The increase in payments resulting from casemix "upcoding" entirely offsets the 3.6 percent increase in the RPL market basket;
- "current payments are more than adequate to account for price increases in the services furnished by LTCHs during the 2007 LTCH PPS rate year".

Casemix "Upcoding"

- ***"Real" casemix growth from 2003 to 2004 is equal to the average annualized pre-PPS casemix growth from 2001 to 2003.*** We question CMS' assumption that "real" casemix growth under the LTCH PPS is equal to casemix growth pre-PPS. The average intensity of Medicare inpatients in Long Term Care hospitals may, in fact, be increasing from pre-PPS levels as acute hospitals discharge sicker patients to LTCHs.
- ***This 4 percent upcoding is conservative, given the 5.35% coding "creep" a RAND study of acute hospitals determined.*** We question the pertinence of a 19-year study of an entirely different set of providers (acute hospitals) for the evolving LTCH PPS. We contrast this with the one-time casemix adjustment applied to the Inpatient Rehab Facilities in their 2006 rule, using mature IRF data.
- ***Payment growth (17%) from 2002 to 2003 exceeded cost growth (8%).*** The interplay between cost and payments in a PPS cannot be expected to perfectly correlate at each point in time – rather, it is cyclical. For example, at one point in the cycle, a portion of additional intensity is "absorbed" within the hospitals existing cost structure, resulting in increased productivity. At some later point, additional intensity increases can no longer be absorbed, leading to additional cost increases, likely outpacing the corresponding payment increases.
- ***One LTCH was found to have a majority of patients not at hospital-level of care.*** As we will note below, concerns regarding the appropriate hospital level of care should be addressed through QIOs or some other measure of the necessity of care, not indirectly through the payment system.

Current payment adequacy: CMS cites several factors as proof that current payments are more than adequate:

- ***12.0 percent Medicare margin in 2004.*** We concur that Medicare payments must be based on the cost of efficient providers – and we acknowledge MedPAC's recommendation of a 0 percent update. We ask CMS to consider that efficient providers need a modest margin, roughly 4 to 5 percent, to invest in the future, particularly investments strengthening and enhancing the quality of care. As taxpayers, we concur that a 12.0 percent margin exceeds this benchmark – the crucial question, however, is whether current margins remain at this high level. We note that MedPAC projects overall LTCH margins will drop to 7.8 percent in 2006, while Lewin projects a drop to 9.2 percent. The average of these two estimates, at 8.5 percent, is still healthy but now within 4 percent of the

benchmark margin. (We note that MedPAC's estimate takes into consideration the overall 6 percent reduction in payments resulting from the DRG re-weighting in 2006.) Setting prospective payment rates based on prior year margins is, we believe, very risky business - akin to steering a car forward by looking in the rear-view mirror.

- ***Tremendous growth in LTCHs***. The growth in LTCHS over the past several years may be indicative of a payment system that has been more generous than warranted. However, it may also indicate that LTCHs' place on the continuum of care is evolving in other parts of the country. At any rate, any resulting response must be measured and targeted so as not to disrupt the network of care, particularly in places like Massachusetts where LTCHs place in this network has been long established and, consequently, there are few alternative sites of care in place.

Recommendation

Elimination of the update constitutes a permanent reduction in payments, reducing the LTCH payment base forever – there is no turning back. Consequently, the rationale for such a permanent cut must be certain and permanent as well. We have concerns with both:

- Certainty: Increases in casemix pre-PPS may indicate "true" casemix increases post-PPS – yet, they may not. We do not believe CMS has sufficiently demonstrated that there is no other "real" factor increasing casemix beyond the pre-PPS rate of increase. We suggest that CMS replicate the approach it used to determine the one-time casemix adjustment for Inpatient Rehabilitation Facilities (IRF), particularly its use of mature IRF data.
- Permanence: CMS must also demonstrate that the "coding creep" payment lift remains in the "base" forever as well. Yet, DRGs were re-calibrated in 2006, resulting in a reduction in casemix, ***and therefore, in payments***, of six percent. We believe, therefore, that the payment base has already been reduced for coding creep.

We therefore recommend that CMS provide the full market basket update for LTCHs for 2007.

II. Proposed Adjustments for Special Cases

CMS has made it clear that it has been seeking the answer to the following question: where is the proper place for LTCHs along the continuum of care for Medicare beneficiaries and how is this place substituted for in areas where there are no or few LTCHs. We believe this to be a proper question to ask for a prudent purchaser of care. As an integrated delivery system, we are completely committed to the right care, in the right place, at the right time. We have put in place a number of system-wide initiatives to strengthen the continuum of care among our network of providers, at all times keeping the needs of the patient first and foremost. In order to place the care of the beneficiary

first and foremost, we believe CMS must arrive at a clinically based "answer" to its question about LTCHs. And to CMS' credit, it is seeking such a clinical answer through the RTI study.

For this reason, we were taken aback to find that, in this proposed rule, CMS has suddenly determined that LTCHs are not currently occupying their proper place on the care continuum simply because too high a proportion (37 percent) of the cases treated by LTCHs have lengths of stay less than 5/6ths of the geometric mean length of stay (GMLOS). And we were stunned to learn that CMS' response would not be the precise, targeted clinical criteria being developed by RTI, nor clinical criteria being developed by others, including NALTH, but rather a blunt, across the board payment approach, intended to make the site of care decision for nearly 40 percent of patients currently treated by LTCHs based on payment rather than clinical decision making. The severity of this reduction in payment for 40 percent of current LTCH patients literally boggles the mind. According to Lewin, the margins on SSO cases will drop to a negative 81 percent under the proposed SSO payment policy. Even more egregious is the fact that these SSO cases are currently playing a key role in keeping overall PPS payments in balance. As CMS has cited in virtually all PPS rulemaking, this balancing of payments is the most fundamental tenet of PPS – an average payment specifically set to overpay some cases, underpay others, with total payments intended to cover the cost of efficient providers. As Lewin points out, the proposed SSO payment policy not only eliminates this fundamental averaging, it in fact ***reverses it.***

In the proposed rule, CMS makes a number of statements indicating that care for many SSOs should either remain in the acute care hospital or be provided in some other setting. Regarding continuing care in the acute hospital, CMS states (with emphasis added):

- Since the vast majority of LTCH patients are admitted directly from IPPS acute hospitals, we believe that the admission of short stay patients at LTCHs ***may indicate*** premature and even inappropriate discharges from the referring acute care hospitals.
- To remove what ***may be*** an inappropriate financial incentive and to discourage LTCHs from behaving like acute 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 hospitals, we are proposing to add a fourth payment method – payment comparable to IPPS

Yet,

- Many patients treated in LTCHs have survived critical illnesses, all treated in acute care hospitals, many in the ICUs – with all due respect, we ask CMS where else these patients should be admitted from;
- SSO lengths of stay are not commensurate with acute hospitals, as the following comparisons determined by Lewin clearly demonstrate:

- The ALOS of SSOs, at 12.7, is 72 percent higher than that of acute hospitals (7.4). This disparity grows to nearly 100 percent when measured by the GMLOS;
- 86 percent of SSOs have lengths of stay exceeding the mean IPPS length of stay;
- The ALOS of SSOs for the 3 highest volume LTCH-DRGs reveals length of stays that approach or exceed the 25-day ALOS requirement for qualification as a LTCH;
- The mean DRG weight for SSOs in DRGs common to both LTCH and acute IPPS is 76 percent higher than in the acute hospital; and,
- SSO cases that would be reimbursed at IPPS levels under the proposed SSO Policy have a casemix index 109 percent greater than acute care patients assigned to the same DRGs.

It is totally inappropriate to take a payment based on the set of illnesses, treatment patterns and cost structure of one set of providers and simply overlay that onto the different illnesses, treatment patterns and cost structure of a different set of providers. In fact, NALTH makes what we believe to be a convincing case that imparting IPPS payments on the LTCH PPS is directly contrary to the LTCH PPS enabling statute.

CMS states in the LTCH proposed rule that it does not want to pay for this care twice – once in the acute hospital, again in the LTCH. We find this statement particularly troubling in light of the fact that CMS has made ***this exact same argument*** in several IPPS proposed rules over the recent past in support of its proposals to expand the post acute transfer policy, culminating in this year's (IPPS Rate Year 2006) near-full expansion of the post acute transfer payment policy, ***reducing payments to acute care hospitals by $900 million in 2006.*** This "squeezing of the middle" is, grossly unfair to providers.

Regarding other sites of care, CMS states (again with emphasis added):

- We believe that the 37 percent of LTCH discharges that the FY2004 MedPAR identified as SSO cases continues to be an inappropriate number of patients being treated in LTCHs who ***most likely*** do not require the full measure of resources available in a hospital that has been established to treat patients requiring long-stay hospital-level care.
- The current payment mechanism ***may*** unintentionally provide a financial incentive for LTCHs to admit patients not requiring the level of care available in that setting.

Yet,

- The level of 37 percent represents a 23 percent reduction from the level of SSOs a mere two years earlier;
- As Lewin demonstrates, the 37 percent distribution of SSOs is the mathematical result of defining SSOs at the 5/6 GMLOS threshold. The proportion of SSOs

will remain at approximately one-third of cases as long as SSOs are defined by a threshold of 5/6 GMLOS;

- The full measure of LTCH resources are often not provided consecutively but rather simultaneously under a multi-disciplinary approach. In fact, many SSOs represent the "success stories" of this multi-disciplinary approach, where rehabilitation services are provided at the same time medical issues are resolved. We note the study by the Barlow Respiratory Hospital Research Center (cited in the NALTH comments) that demonstrated that LTCHs were considerably more successful than acute hospitals in weaning patients from mechanical ventilation.

Furthermore, we note that each of the above statements by CMS is qualified, as we have highlighted above. CMS would not have qualified these statements if hard fast, irrefutable data had been available. Yet, an "outside" reviewer would very likely conclude that such hard fast, irrefutable data must exist to justify the magnitude of the proposed changes.

Finally, we express our strong objection to the fact that CMS, through this proposed SSO payment policy, is overriding the medical necessity decisions that Congress has delegated to the QIOs. As NALTH states in its comments: "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."

Recommendations

We have given a great deal of consideration to what recommendations we should offer to CMS regarding the SSO payment policy. We remain committed to our long-standing principle of maintaining a balanced approach in such recommendations, striving to achieve what we believe is the best balance between the concerns raised by CMS and the needs of our providers and providers in general. As such, we offer the following recommendations:

1. Consideration of a two-year moratorium on new LTCH Providers. We acknowledge CMS' previous efforts on this front, including testimony before Congress that was not successful. However, we believe this option should be reconsidered given the concerns raised by CMS in the proposed rule. (We are cognizant that such an action would require legislation.)
2. Intensify and expand QIO review. The over-arching thread running through the preamble is CMS concern regarding the appropriateness of care in LTCHs. We cannot overstate our firm conviction that LTCHs provide efficient and effective care to the medically complex Medicare beneficiaries (and all patients) in a multi-disciplinary and comprehensive manner. Likewise, we cannot overstate our conviction that appropriateness of care must be determined clinically, not through disincentives in the payment system. QIOs already have the mandate

from Congress and the infrastructure already in place, therefore requiring relatively little lead-time in ramping up their efforts. We would anticipate at least some results from this intensified and expanded review would be available for next year's proposed rulemaking.

3. Establish a payment methodology for "very short stay" cases, defined as cases whose length of stay falls below 20 percent of the GMLOS for the applicable DRG. For example, the GMLOS for LTCH-DRG 271 is 27.7 days. A very short stay case for LTCH-DRG 271, therefore, would be a case whose length of stay is 5 days or less. We suggest payments for these cases at the lower of:
    a. 120 percent of the LTCH-DRG per diem amount multiplied by the LOS of the case;
    b. 100 percent of the cost of the case; or
    c. the full LTCH-DRG payment.
4. Maintain the current 3-tiered payment methodology for all other SSOs, i.e., cases whose length of stay falls between 20 percent of the GMLOS for the applicable LTCH-DRG and 5/6 of the GMLOS, but reducing the cost option to 110 percent of the cost of the case. Again, to be clear, payment for these cases would be the lower of
    a. 120 percent of the LTCH-DRG per diem amount multiplied by the LOS of the case;
    b. 110 percent of the cost of the case; or
    c. the full LTCH-DRG payment.

We further recommend that CMS monitor SSOs closely as well as the overall margins in the industry. ***To be absolutely clear, we urge CMS, in the strongest manner possible, not to implement the IPPS payment option. Doing so will surely restrict access by Medicare beneficiaries to acute care hospitals and long term care hospitals and threaten the viability of LTCHs.***

We thank you for the opportunity to comment. Please contact David Storto, President of Partners Continuing Care, at (617) 278-1077, should you, or your staff, have any questions regarding these comments or would like additional information. We offer any assistance we can provide to CMS to improve the care of Medicare beneficiaries in Long Term Care Hospitals and the LTCH payment system.

Sincerely,

James J. Mongan, MD
President and CEO

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March 16, 2006

MAR 17 2006

Dear Administrator McClellan

I would like to add that now is the time to do something for me as I have for you in contributing to your successful seat in the Senate.

As you are aware, we are in the generation of the "Baby Boomers" and **our** parents will eventually need more healthcare providers and facilities. Imagine having a parent in an acute care hospital, not fully recovered from their illness/surgery and told by their case manager that "it's time to move to the next level of care". That next level of care would be either home with "limited" home healthcare providers due to healthcare cutbacks; or having your parent sent to a SNF (Skilled Nursing Facility/nursing home) that has a physician who sees them maybe once a week and the facility has a patient ratio of 10 patients to one nursing assistant overwhelmed due to understaffing again from healthcare cutbacks.

There have been many times where an LTAC, such as SCCI Hospital, has been able to bridge the "next level of care" safely for those patients and family members who have had to make this type of decision. Most of our patient's family members are both working and are unable to provide the higher level of care needed. Picture one of your in-laws at home on a ventilator requiring frequent suctioning for the removal of secretions and treatments to heal a non-surgical wound due to their long standing history of diabetes. Both you and your spouse need to work in order to maintain your home life and no-one is able to be of service in caring for this person who is depending on you to care for them. Scary isn't it?

Once again, please address this proposed rule with an open mind. Keep in mind your aging parents as well as yourself and your children, who will need to decide one day the type of healthcare and facility that is best for you and for them.

Sincerely,

Christine Kressler

Christine Kressler, RN

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March 13, 2006

Honorable Mark B. McClellan
Administrator, Centers for Medicare & Medicaid Services
Dept. of Health and Human Services
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7500 Security Blvd.
Baltimore, MD 21244-8012

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

Dear Administrator McClellan:

I am writing to express my opposition to your proposed rule to reduce Medicare reimbursement to long-term acute care hospitals. Any proposed changes in payment for these hospitals should be based upon objective data not wishful thinking. Changes should not be implemented until the CMS-commissioned study is complete and objective solidly based criteria are developed to support any recommended changes.

Changing the rules without a proper assessment is likely to have a devastating impact on patient care as well as access to care. The proposed rule changes will cause some long-term acute care hospitals to close which will make care unavailable for patients in need. These hospitals care for long term intensive care unit type patients most of whom are critically ill. Long-term acute care patients are quite different from those in short-term acute care hospitals.

Sincerely,

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CC: Randall G. Stokes

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March 17, 2006

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

Re: CMS' Proposed Changes to the Long-Term Care Hospital Prospective Payment System for FY 2007

Dear Dr. McClellan:

Thank you for the opportunity to respond to the proposed rules for long-term acute care hospitals (LTCH) staged to go into effect on July 1, 2006. As the President and Chief Executive Officer of the Good Shepherd Rehabilitation Network, a post-acute continuum serving northeastern Pennsylvania, I write to you on behalf of our Board of Trustees, Medical Staff, Clinical and Administrative staffs, and the patients and families we serve to express our strong opposition to the proposed rule.

Supported by the opinions of our industry organization, the National Association of Long-Term Hospitals (NALTH), and research conducted by The Lewin Group, the five strategic parameters of the rule will literally derail the LTCH industry, putting thousands of health care professionals out of work and most importantly result in severely reducing access to care for the American public and causing a back-up at the front doors of the nation's emergency rooms for those seeking care, but finding that there is no room in their community acute care facility.

One change that Good Shepherd does support is the adoption of the proposed Rehabilitation, Psychiatric, Long-Term Care (RPL) market basket. However, there are five other major strategies we strongly oppose:

- Reducing reimbursement of short stay outlier (SSO) cases at payment levels below the current status, with more than 80% expected to be paid at the acute IPPS rate.
- Increasing the high cost outlier threshold amount from $10,501 to $18,489.
- Imposing a zero (0%) percent update for FY 2007.
- Eliminating the surgical exception to the interrupted stay policy.
- Revising the manner in which cost to charge ratios are calculated.

All tolled, these five devastating strategies are expected to reduce Medicare expenses to the long-term acute care industry by 11%. What the rule fails to recognize is the clinical acuity of these patients, who by their disease trajectory and clinical criticality require high resource utilization. Aging baby-boomers, high risk health behaviors, resistant super bugs and consumer demand for advanced technology all contribute to the criticality of conditions that typify an LTCH population. In fact, Lewin showed that LTCH SSO cases expected to be reimbursed at an Inpatient Prospective Payment System (IPPS) payment rate have a case mix index 109% greater than the case mix for patients in acute care.

Good Shepherd Specialty Hospital (GSSH) is a 32 bed hospital-in-hospital LTCH serving more than 5 counties in northeastern Pennsylvania. Since its opening in January 2000, GSSH has had the opportunity to care for nearly 2000 patients and their families. The care delivered by the clinical staff, guided by the mission and core values of Good Shepherd, is exceptional. Like other LTCHs, we care for the sickest of the sick, a critically ill, medically unstable population requiring close supervision and monitoring to wean from the ventilator, progress complex wounds to healing status and slow progressive rehabilitation to improve functional status, which has been severely compromised by multi-system disease. Patients and their families choose GSSH because it is part of the Good Shepherd network which has a 100-year tradition serving the Lehigh Valley community and because of its successful outcomes such as a 95% weaning rate and progressing more than 60% of complex wounds to healing status within 5 weeks.

The proposed rule is unprecedented in the magnitude of payment reductions which would result in fiscal harm to GSSH, along with many other LTCHs in the industry. The projected impact to GSSH would be a reduction in payments by more than $2.5 million, a 20% operating loss. The rule jeopardizes the viability of our LTCH operation.

The SSO strategy is the most devastating of all of the points. The CMS policy that predicates the SSO proposal assumes that SSO cases have a length of stay commensurate and somehow comparable with patients admitted to acute care hospitals. The significant flaw is that the policy does not recognize the clinical criticality of these cases and thus is factually wrong and logically flawed. The Lewin study, as well as our own internal one, validates that SSO cases have significantly longer lengths of stay than the comparative DRG in the acute care IPPS system. Higher acuity of LTCH SSO cases is further demonstrated by higher mortality rates, 19.61% as compared to 4.81%, for SSO in acute care hospitals. In fact, Lewin calculated that the average geometric mean for Long Term Hospital Prospective Payment System (LPPS) cases was 10.8 days in comparison to the IPPS of 5.6 days, representing a 93% difference. The SSO strategy poses to eliminate these cases from receiving care in an LTCH. If that were to occur, such patients would likely remain in an acute care setting, thus reducing access to care for others with greater need of an acute care hospitalization.

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 severe 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. NALTH sponsored a multi-site study conducted by the Barlow Respiratory Hospital Research Center. The study included data on 1,419 patients who were admitted to 23 LTCHs located throughout the country, which had active ventilator weaning programs. Of all the patients studied, 453 or 32% had stays of less than 29 days, which means they would qualify as SSO 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. If the SSO policy were to achieve its objective, 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 to receive care under the multidisciplinary team and programmatic approach available in LTCHs, which in turn 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.

Lewin has challenged the CMS assumption that SSO cases must constitute approximately 35% of LTCH patients regardless of hospital and physician patient selection policies. CMS uses a relative measure of "short stay" that guarantees that approximately 30% to 40% of cases will always be considered "short." Mathematically, stays less than 5/6 of the geometric mean will always be considered "short." The rule contends that 37% of LTCH cases are short stays. To object to the fact that this is too many, when in fact it is mathematically impossible to be

less than that by its own "short stay" definition, is akin to objecting to the fact that LTCHs have 50% of cases that fall below the median.

In 2005, CMS introduced the 25% restriction to hospital-in-hospital LTCHs from receiving more than 25% of its patients from their host facility. Like the SSO rule, the 25% rule ignores the clinical criticality of these patients. NALTH warned that it was not unusual for any LTCH hospital-in-hospital or freestanding to receive a majority of patients from a single source. Although the 25% rule halted the growth of hospital-in-hospital LTCHs, the freestanding sector has continued to grow and CMS has now recognized that NALTH's position was true. Lewin's final report cites that 93.7% of free-standing rehabilitation hospitals receive 25% or more of their admissions from a single acute care hospital. The LTCHs that comprise NALTH's membership are truly experts in the industry. Amassed among the membership are hundreds of years of experience in the 20+ year legacy of the LTCH industry. In respect of the foundational principles of quality, I urge CMS to recognize "the people, who do the work, are experts of the work." Thus, when the membership supports the fact that limiting access to LTCH care will cause a back-up at the front doors of America's emergency rooms, CMS should heed the warning and work with the membership and others in the LTCH industry to address the Administration's desire to curb unnecessary spending and still support the greatest healthcare system worldwide.

For example, since the 2002 MedPAC study, CMS acknowledged the need for admission criteria to regulate the industry, along with recommendations to have designated Quality Improvement Organizations (QIO) review the medical necessity of LTCH patient admissions. While the QIOs have enacted a fair, yet rigorous system to assure competent coding and billing practices, the industry still awaits the introduction of uniform admission criteria. In fact, in its March 2006 report to Congress, MedPAC reiterated its recommendation that QIOs should review the medical necessity of admissions to the LTCH. Good Shepherd wholeheartedly supports this recommendation as an alternative to the enactment of the SSO rule. In addition, we support the NALTH recommendation which suggests creating an "ultra short stay" classification which pays at 80-90% of costs for cases that stay less than 20% of the geometric mean. Excluded from this group are cases discharged due to death.

It is of vital importance to the patients of Good Shepherd that the proposed LTCH rule not be adopted as written. Instead, Good Shepherd urges CMS to study the final report of the Lewin Group challenging the rule, as well as work with the NALTH membership and others in the LTCH industry to establish changes in policy that will respect the economic welfare and growing healthcare needs of our country.

Sincerely,

Sally Gammon
President and Chief Executive Officer
Good Shepherd Rehabilitation Network

Form letter #57

LIFECARE
HOSPITALS
of FORT WORTH

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

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

Dear Administrator McClellan:

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

I have been the Director of Case Management at LifeCare Hospitals of Fort Worth for eight years and previously worked for six years at another long term acute care hospital. I have also worked in a short term acute care hospital.

From the perspective of my experience in both settings, I feel very strongly that this level of care plays an essential role in the health care continuum. Treatment options for the patients with whom we work are extremely limited. These are very ill patients with complex medical conditions and debilitation. Because they need specialized medical services and daily physician visits, these patients cannot be effectively treated at a lower level of care. Many of them require treatment modalities such as ventilator weaning, dialysis, and intensive wound care that are not available to them in a nursing home setting.

Your suggestion that long term acute care hospitals are seeking out short stay patients is entirely untrue. Because of their medical complexities, it is impossible to determine their response to treatment or the length of time they will need to be hospitalized.

In my role as a Social Worker and as a Director of Case Management, I have seen, time after time, the benefit of this level of care for patients who would otherwise have little or no chance for recovery. I have spoken to their families who had lost hope and have had that hope renewed.

Another very valuable role that we play, for those patients with little hope of recovery, is that of assisting their families to accept this reality and to make the

decision to stop further aggressive care. This process does not occur in the short term acute care setting. Assisting with this process ultimately benefits the entire health care system by saving significant costs and resources. Because hospital stays are often shortened by this process, with your proposed rule they would be punished for it, despite its obvious benefit.

If long term acute care hospitals are not available for this group of patients, they will require longer stays or frequent re-hospitalizations, at a higher cost, to a short term acute care hospital.

I hope that you will reconsider this proposed rule which could deny patients access to services vital to their recovery.

I thank you in advance for your consideration regarding this very important matter.

Sincerely,

Gail Berky, LMSW, CCM

Gail Berky
Director of Case Management, LifeCare Hospital of Fort Worth

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:

As the President of Allegheny General Hospital in Pittsburgh, I am concerned and do not support your proposed rule to reduce Medicare reimbursement to long-term acute care hospitals.

As a large tertiary care hospital anticipating a growing Medicare population, we are concerned about the potential reduction in options for post-acute services. Today we encounter many patients who require the specialized services of Long-Term Acute Care hospitals. Routinely, we utilize the services of local long-term care hospitals to assure patients receive the care appropriate for complex cases over an extended period of time. The proposed rule will have a devastating impact on patient access to the continuum of critical care services.

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

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

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

Sincerely,

Connie M. Cibrone
CEO and President, Allegheny General Hospital

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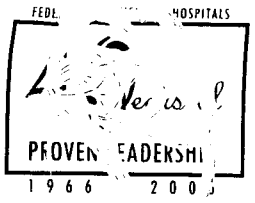
Federation of American Hospitals®



March 20, 2006

VIA HAND-DELIVERY

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445--G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

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

Dear Dr. McClellan:

This letter presents comments and recommendations of the Federation of American Hospitals ("FAH") to certain aspects of the proposed annual payment rate updates, policy changes, and clarifications under the Prospective Payment System for Long-Term Care Hospitals ("LTCH PPS") for fiscal year ("FY") 2007, which were published by the Centers for Medicare & Medicaid Services ("CMS") on January 27, 2006 (the "Proposed Rule").

The Federation of American Hospitals is the national representative of investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural parts of the United States. We appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' ("CMS") Proposed Rule regarding changes to the Long-Term Acute Care Hospital ("LTCH") Prospective Payment System ("PPS") for Rate Year ("RY") 2007.

As we discuss more fully below, FAH opposes many of the severe and arbitrary reductions in long-term care hospital payments that will result if these proposed changes to the LTCH PPS are implemented. FAH believes that in the case of this Proposed Rule, CMS has introduced certain measures and payment principles that are unworkable in practice and conceptually flawed. In addition, many aspects of the Proposed Rule essentially seek to blur key distinctions between LTCHs and shorter

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stay general acute care hospitals that the Congress has mandated, essentially assuring a system where patients will find it more difficult to receive care in the most appropriate and beneficial type of facility.

FAH has analyzed the Proposed Rule and believes that CMS has also used seriously flawed, and in many cases incomplete, data in developing their proposed changes to LTCH payments for RY 2007. FAH's analysis shows that many of the assumptions CMS has made in developing the Proposed Rule are inaccurate as a result of the data errors discussed herein, and are unsupported by clinical data or an objective measure of cost savings across the many types of providers that ultimately will be affected by this Rule, that is, short stay acute hospitals, long term care hospitals and skilled nursing facilities. FAH believes, therefore, that CMS should (i) withdraw the proposed rule, (ii) revise the data it is using to develop final payment changes for LTCHs in FY 2007 to correct these data errors, (iii) study the impact of the Proposed Rule on clinical outcomes and the cost of care across all affected providers, and, (iv) publish a new proposed rule that will allow for interested and affected parties to provide meaningful comments.

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

FAH is particularly concerned at the prospect that general acute care hospitals may be overtly encouraged (or forced) through the regulatory changes to payment proposed in this Rule to attempt to treat a much larger number of longer term patients. Long term patients constitute a distinctly different patient population than shorter stay general acute care patients. General acute care hospitals are not generally structured to treat long term care patients, who have specific medical needs for their often chronic conditions, with major co-morbity factors and high severities of illness. LTCHs provide a critically necessary treatment option for this distinct niche of severely ill patients as was required by Congress in establishing a separate category of hospitals under the Medicare statute. From a clinical outcomes perspective, a general acute care setting may not be the most appropriate setting for the care of these patients when compared to the care available to them in an LTCH.

In particular, CMS should reconsider its proposed policy for short-stay outlier ("SSO") cases. CMS makes the erroneous assumption that all so-called "short stay" cases – even those whose stay exceeds the statutory threshold of 25 days to qualify as an LTCH – should never have been admitted to an LTCH and should have been paid at a lower rate (in this case, rate that actually fails to cover costs). To the extent that CMS is concerned about "inappropriate" admissions to LTCHs, it should implement non-payment related approaches to address its concern, such as pre-admission physician certifications, uniform admission screening criteria, and more extensive Quality Improvement Organization ("QIO") reviews. Alternatively, CMS should consider more narrowly tailored payment reforms targeted specifically at "very short stay" LTCH patients (*e.g.*, patients with lengths of stay of less than 7 days).

FAH understands CMS' need to review regularly the efficiency, economy and efficacy of its many health care programs, including LTCH PPS. FAH also recognizes that the objectives of controlling costs while continuing to make high quality health care available to those most in need are

not easily achieved and present significant challenges to all facets of the healthcare industry. Nevertheless, FAH firmly believes that CMS has moved too quickly and too far on the payment side in this case and has raised very serious issues that threaten LTCHs' continued ability to provide care for a large segment of the very sick population they serve. The proposed changes will likewise place undue pressures on both general acute care hospitals and LTCHs to make difficult decisions regarding admissions and discharges that may not result in the most appropriate placement of a large group of severely ill patients.

I. Proposed Changes to Short-Stay Outlier Payments

A. Summary of Proposed Changes

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

CMS proposes two specific changes to the SSO payment methodology in the Proposed Rule. First, CMS would reduce the first part of the current payment formula that is based on costs from 120 percent to 100 percent of the costs of the case. Second, CMS would add a fourth component to the current formula that would allow payment under the LTCH PPS based on an amount purportedly comparable to what would be paid to an acute care hospital under the inpatient prospective payment system ("IPPS"). That is, for SSO cases, LTCHs would in the future be paid based upon the lesser of four amounts, one of which would be an amount "comparable" (though not equivalent) to the IPPS payment for the patient stay. Each of these changes would be effective for discharges on or after July 1, 2006. CMS apparently believes that, under this proposed policy, LTCHs could be paid by Medicare under the LTCH PPS at a rate that is more consistent with the rate paid to acute care hospitals when the LTCHs treat patients whose stay is less than or equal to five-sixths (5/6) of the geometric mean length of stay for a particular LTC-DRG. FAH believes that the data cannot support such a change.

B. The Proposed SSO Policy Is Not Supported By The Data

1. Contrary To Established PPS Principles, The Proposed Rule For SSOs Virtually Guarantees That No Case Can Be Paid At Greater Than Its Cost And That Most Will Be Paid Below Cost.

CMS's proposal to limit the payment for SSO cases to the IPPS payment rate for such cases would cause LTCHs to be significantly underpaid. For SSO cases, which CMS acknowledges represented fully 37 percent (as of FY 2004) of the patients served by LTCHs, the proposal would actually cause payment amounts to fall materially below the actual costs of providing care. Payment to the over forty (40) LTCHs operated by one of FAH's members for SSO cases under the payment methodology of the Proposed Rule would equal only 57 percent of the actual costs incurred in caring for those patients in the first year of the policy.

Overall, CMS's proposal would slash payments to LTCHs by approximately 11 percent, according to CMS' own calculation. Combined with a separate proposal to deny the basic inflationary

update to cover the rising costs of care, which CMS estimates to be 3.6 percent, and other recent changes to LTCH coding and LTC-DRG weighting, the impact of the proposed revisions to the SSO payment policy will be to pay LTCHs *significantly* less than it costs them to care for appropriately admitted patients. Patients with complex medical conditions will likely lose access to needed hospital care, and general acute care hospitals will needlessly and unfairly incur additional costs since they will likely be unable to discharge these complex patients to a more appropriate setting.

Moreover, LTCHs will not be able to make up these costs from other patients. An analysis prepared by the Acute Long Term Hospital Association ("ALTHA") shows that, after giving effect to the proposed SSO payment policy and the lack of any inflationary update, the total payments to LTCHs will fall short of LTCH costs by 7.7 percent.[1]

CMS appears to assume that LTCHs can change their behavior so as to accommodate this dramatic reduction in payments. In particular, CMS claims that LTCHs will decline to admit SSO patients, since the costs of treating such patients will exceed the proposed payment amounts. But, assuming for the moment that this turns out to be the case, where are these patients supposed to go? It is both medically short-sighted and economically questionable to expect general acute care hospitals to retain patients two and three times their normal legnths of stay simply because LTCHs are urged to reject patients that may not complete what CMS determines should be a full LTCH stay. The only potential alternative is a subacute SNF unit where the length of stay, and the costs of care, may greatly exceed the cost of care at an LTCH.[2] General acute care hospitals are not set up to provide the type of care needed by the long term care patient population. Similarly, extra long general acute care stays will undoubtedly have the effect of driving up IPPS outlier payments or cause adjustments in IPPS outlier payment thresholds that will adversely affect segments of the acute care hospital industry that cannot afford such effects such as rural and sole community hospitals. And, if LTCHs do not reject such patients in need, LTCHs will be forced to absorb payment rates, contrary to long established Medicare principles, well below the cost of delivering care.

The magnitude of the proposed cuts in payments for treating SSO patients is so dramatic that the proposal appears to be nothing short of punitive. Although apparently intended to punish LTCHs for inappropriately admitting patients not in need of LTCH care, CMS points to no study indicating that inappropriate admissions constitute a material portion of SSO cases. To the contrary, the data presented below demonstrates that the vast majority of SSO cases are, in fact, appropriate for admission to LTCHs.

CMS' proposed draconian shift in LTCH payment policy, coming so quickly on the heels of the initial LTCH PPS rate setting process, the initial budget neutrality adjustment and the few subsequent annual updates, also raises the question of the continued appropriateness of the LTCH payment rates overall. At the time(s) CMS established the various features of LTCH PPS and subsequently computed annual updates since that time, CMS' calculations necessarily contemplated the existence of an SSO

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[1] *See* Figure 1 to Comments submitted by ALTHA to the Proposed Rule, March 10, 2006. (Exhibit 1.)

[2] There is no evidence in the Proposed Rule that CMS studied, considered or had available to it studies of: (a) the possible clinical outcomes from the impact of the change in behavior the Proposed Rule intends to encourage, or (b) the cost of care that would result from a change in admission behavior resulting in longer stays at short stay hospitals, or stays longer than LTCH stays that may occur if these patients are admitted to skilled nursing facilities ("SNFs").

patient population comparable to, if not greater than, the percentage (37% of the FY 2004) identified in the January 2006 Proposed Rule. Consequently, payments for care furnished to that SSO population, based upon the ("lesser of") SSO methodology in effect since the initial implementation of LTCH PPS, necessarily also would have taken into account the amounts of those payments for SSO cases under the existing SSO methodology. These previously anticipated SSO case reductions also necessarily impacted other elements of LTCH PPS, such as the standard federal rate. To decimate SSO payments so drastically now on the basis of only one full year's data experience since the implementation of LTCH PPS, without a corresponding increase in payment rates for non-SSO cases, calls into clear question the ongoing fairness and viability of the overall LTCH PPS payment system.

2. The CMS Analysis of Short-Stay Outlier Cases Runs Contrary to CMS' Long Established Methodology of Updating Reimbursement Policies Based on Historical Data

Contrary to its normal and historical practice, CMS has "rushed to judgment" in this case and seeks to update reimbursement policies based on a paucity of data, from a very limited period of time, with potentially disastrous results for LTCH providers, general acute care providers, and the truly and severely ill patients LTCH providers presently serve.

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

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

Assuming that the LTCH SSO percentage at the outset of LTCH PPS was 48%, and further that many LTCH providers had only a few months (if that many) of LTCH PPS experience in the first LTCH PPS fiscal year (FY 2003) (which clearly was the case), comparing FY 2003 with FY 2004 reveals that short-stay outlier cases decreased in the first <u>full</u> year of LTCH PPS by no less than approximately 30% (29.7%). Moreover, existing regulations provide that each LTCH payment was comprised of (no more than) 40% of the federal prospective payment rate during FY 2004, whereas 60% of each LTCH payment was still paid as cost based reimbursement for the LTCHs that, as of 2004, had chosen to transition to the LTCH PPS and did not immediately convert to the PPS federal rate. Thus, the incentives that CMS indicated it built into the LTCH PPS to pay LTCHs for patients who likely could not be more appropriately treated in other types of facilities would not yet have been fully reflected in FY 2004, since many LTCHs continued to be paid 60% of their reimbursement based on their costs during that year.

To engage in any credible analysis, CMS must examine the remaining number of SSO cases and the more comprehensive LTCH cost report data at the conclusion of the transition, or in any event, no earlier than as of the end of FY 2005 (the first year in which more than 50% of each LTCH PPS payment could have been comprised by the federal rate, and thus could have been subject to a meaningful impact by the presently existing SSO payment criteria). Only after such analysis can CMS make a rational decision as to whether or not SSO cases remain a material segment of LTCH discharges. The mere fact of a 30% reduction between the onset of LTCH PPS and the first year of full participation (albeit on a relatively small percentage basis) suggests that when new data are reviewed, there may be further and significant reductions to the SSO case percentage, based on the limits, controls and incentives that are already in place.

b. CMS Failed to Assess Which Types of Short-Stay Outlier Cases Could Bear Any Meaningful Relationship to CMS's Stated Policy Goals

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

Such a view simply ignores available data showing that (1) some portion of SSO cases involve patients whose medical condition made them appropriate initially upon admission for the level of care provided by LTCHs, but whose condition may have improved enough to warrant further treatment in alternate and less intensive care settings; (2) some portion of SSO cases involve patients that die during their LTCH stay; and (3) some portion of SSO cases may be admitted to an LTCH, but are later discharged after the patient's care providers determine after further examination and treatment that the patient could more appropriately be treated in some other type of facility. Only the third category of SSO cases described above lends itself at all to the concern CMS expresses in the Proposed Rule that many LTCH cases are not appropriate for the LTCH level of care.

If all or most SSO patients did not require an LTCH level of care – that is, they required less intensive services – then the CMS statement above may suggest the need to bring payments more in line with the proper incentives. According to data submitted in Table 4 of Comments to the Proposed Rule submitted by ALTHA (Exhibit 2, hereto), however, there are no material differences between SSO patients and full-stay LTCH patients, as measured by both severity of illness and by risk of mortality. This squarely contradicts the assertion by CMS that LTCHs are admitting patients that are "not requiring the level of care available in that setting."

Additionally, there are good explanations for why a patient may be LTCH-appropriate, even if that patient does not stay "for the duration of the LOS associated with the particular LTC-DRG to which the case is assigned." One such example is patients who expire prior to reaching the 5/6th geometric mean LOS threshold.

For example, according to 2004 MedPAR data, 23% of all SSO patients are categorized as SSO cases because they die while an inpatient at an LTCH. There is absolutely no evidence that SSO

patients who expire during an LTCH stay did not require an LTCH level of care upon admission. Obviously, patients are admitted to all hospital facilities generally with the hope that their condition can improve, or at least be managed more effectively. FAH believes it is inappropriate for CMS to imply that any of FAH's member organization's providers operate its facilities in a manner that looks for patients who may perish soon, nor does FAH believe that any other operator of LTCHs would seek to "game" the system in such an inappropriate and unacceptable manner. Patients are admitted because their care givers, families and others in the health care community believe the patients' needs can be best served by admitting them to an LTCH. Because of their severe conditions, some patients die prior to achieving a "geometrically appropriate" length of stay; thus, a SSO case is noted. There are simply no recognizable differences in terms of patient acuity between SSO patients and full-stay LTCH patients, when measured by severity of illness and/or by risk of mortality. CMS chooses, for whatever reason, at this point not to focus on such undeniable facts in promulgating the Proposed Rule's provision on SSOs.

It is further unreasonable for CMS to expect admitting physicians to be able to predict a potential patient death 10 or even 20 days in the future and decline admittance based on that criterion alone in the face of the potential clinical benefits to the patient in the LTCH. Tools simply do not exist for physicians to predict death weeks in advance. The APACHE tool, which is commonly used in LTCHs and short-term general hospital intensive care units to measure patient acuity and resource use, lacks that specificity. Even if a physician could predict an individual patient's LOS and risk of mortality, CMS cannot reasonably assume that an LTCH patient that dies on the 20th day of his stay did not need "long-stay hospital-level care" upon admission. In 2004, 3,847 LTCH patients died within the first week; this represents only 3% of all LTCH cases in that year. Given the clinical difficulties in predicting a patient's length of stay and risk of death as well as the low number of very short-stay LTCH patients due to death, CMS has not offered any clinical basis for the unfounded and financially punitive manner CMS has proposed.

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

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

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

c. CMS Should Follow Its Own Established Process for Reviewing the Appropriateness of Admissions

Medicare QIOs conduct post-admission reviews of LTCH patients to confirm that an admission is medically necessary. At CMS' own direction, QIOs have reviewed a sample of LTCH cases for

admissio appropriateness at numerous facilities, including those of many FAH member organizations. FAH is aware that for one of its member's (Kindred) facilities, one of the largest providers of LTCH care, QIOs have determined that the vast majority of LTCH admissions were appropriate and medically necessary with denial rates well under 3%. The QIO review data does not support CMS's assumption that SSO cases were inappropriately admitted to LTCHs.

d. CMS Failed to Recognize that the Available Data On Short-Stay LTCH Patients and General Acute Care Hospital Patients Shows Marked Differences Between the Two Groups

CMS also appears to have ignored the fact of the clear clinical differences between SSO LTCH patients and general acute care hospital patients. When Congress created the distinct and separate category of LTCH hospitals in the 1980s, it recognized that LTCHs treat a different patient population from that of general acute care hospitals, and a patient population with few, if any, other treatment options. LTCH patients have been shown, again and again, to be demonstrably sicker, with higher patient acuity and multiple medical complexities, than one would find in the typical short-term general hospital patient with similar diagnostic classification. SSO LTCH patients are not clinically identical or even similar to short-term general hospital patients, regardless of the fact that SSO LTCH patients' lengths of stay is less than the average LTCH patient.

CMS' apparent assumptions to the contrary are not based on any credible data set. Data from the 2004 MedPAR[3] file indicate, looking at five of the most common SSO LTC-DRGs and comparing the geometric mean length of stay for those stays with the geometric mean length of stay for the average short-term hospital patient (in the same diagnostic categories), that LTCH SSO patient lengths of stay greatly exceed those of patients treated for similar diagnostic issues in general acute (short-term) care hospitals. *See* Table 3 to ALTHA's March 10, 2006 Comments to Proposed Rule. (*See* Exhibit 3.) These patient populations are not demonstrably similar. Even for SSO cases, LTCHs do not, and should not be expected to, function as general acute providers, or vice-versa.

Once again, CMS' proposed changes to LTCH payment policy have not been founded on sound historical data. Looking at it another way, to view the extent to which CMS' proposed approach contradicts the available data and established regulatory scheme, many types of patients classified as "SSO patients" at LTCHs actually have an average length of stay that exceeds the 25 day threshold that CMS uses to determine whether a hospital is eligible for classification as an LTCH in the first place. Yet, CMS now essentially proposes to treat these types of patients as short-term general hospital patients, and to pay for these patients' lengthy episodes of care on the same basis. This constitutes an unwarranted and unsupported penalty on LTCHs that admit and treat far more medically complex patients than do short-term general acute hospitals; in the alternative, it could result in an unintended and unfair burden placed on general acute care hospitals. Neither result is acceptable to FAH and its varied members.

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[3] Data in Table 3 to ALTHA's Comments to Proposed Rule, submitted March 10, 2006, taken from the 2004 Medicare Provider Analysis and Review ("MedPAR") file, December and March updates.

e. CMS Incorrectly Assumes that LTCHs Can Predict in Advance an Individual Patient's Length of Stay

In developing these proposed changes to LTCH payments for SSO cases, CMS incorrectly assumes that LTCHs can predict in advance the expected length of stay for medically complex LTCH patients. Indeed, CMS did not offer any clinical data to support its assumption. LTCH patients are a relatively homogeneous group of medically complex patients.[4] From a clinical perspective, there are no discernable differences between "short-stay" LTCH patients and longer stay LTCH patients. Physicians who make admission decisions after applying objective and rigorous clinical screening criteria should not, indeed cannot, predict in advance the length of stay for this small subset of medically complex, severely ill patients.

Consistent with the fact that SSO patients require the same level of care as longer stay patients, LTCHs and the physicians charged with assessing these patients are unable to distinguish between these two patient populations at the time of admission. (For the same reason, LTCHs are also unable to identify high cost outliers at the time of admission, and are unable to predict the patient's outcome, including death, at the time of admission.) Data show that patients who are ultimately characterized as SSO cases present the same diagnostic mix, same or higher levels of severity, and higher risks of mortality than longer stay cases. In fact, the percentages of SSO cases falling into each of the most common LTC-DRGs are comparable to the percentages of longer stay patients falling into such LTC-DRGs. DRG classification does not occur until after discharge, when the GROUPER software identifies the proper LTC-DRG for payment. Because the 5/6th geometric stay thresholds are different for each LTC-DRG, it is impossible to predict whether a patient will be a SSO upon admission.

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

Many patients admitted to LTCHs already have had extended stays at acute care hospitals, making it even more difficult to predict how long they will stay. The average DRG 475 short-term hospital patient has a geometric mean LOS of 8 days; but short-term hospital patients who are admitted to LTCHs with DRG 475 have a LOS of 27 days, on average, in the short-term hospital. *See* Table 3 to Comments submitted by ALTHA, March 10, 2006, data extracted from MedPAR 2004. (Exhibit 3.)

Overall, short-term hospital patients sent to LTCHs had prior lengths of stay in the short-term hospital of 13.2 days. This is far in excess of the 5.8 days average length of stay for all STCH patients. This completely refutes any inference CMS may make that STCHs are systematically sending patients to LTCHs before completing their course of care in the STCH. Id.

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[4] *See* Table 2 to ALTHA Comments to Proposed Rule, March 10, 2006. (Exhibit 4.)

CMS also assumes that LTCHs can easily change their behavior so as to accommodate this draconian reduction in payment for SSO cases. CMS suggests that LTCHs simply will be forced to decline to admit SSO patients. This is plainly unrealistic, since it is not normally possible to predict prior to admission whether a particular patient will become a SSO in an LTCH. Although, as discussed above, LTCH patients have a much longer length of stay than the average short-term general acute hospital patient with the same diagnosis, upon entry to an LTCH, there is no magic "marker" or obvious predictive characteristic, at least of which FAH is aware, that can determine whether a particular LTCH DRG 475 patient will stay 18 days, 23 days, 26 days, 29 days, 32 days, 40 days, or three months. To condition so drastic a payment reduction formula on an LTCH's ability to discern the future before it happens, and do so regularly, sometimes three weeks before an event happens, is patently unrealistic and exceedingly unfair.

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

As one can see, therefore, there is no indication, whatsoever, that LTCHs are admitting less acute patients for a short-stay in order to maximize revenues, as CMS asserts. To the contrary, FAH believes that SSO patients are virtually identical to full-stay patients based on several key clinical measures. The most common SSO DRGs are also the most common full-stay DRGs; this suggests that LTCHs are not taking different kinds of patients for short-stays. There are ample reasons why different patients do not stay the same amount of time in an LTCH, including death or better care outcomes.

The average medical complexity (as measured by SOI and ROM) and length of stay of LTCH SSO cases are far higher than for short-term general hospital patients.[5] Thus it is not surprising that the average costs for SSO patients are well above the inpatient prospective payment system ("IPPS") DRG payment amounts. FAH finds no evidence that LTCH SSOs are in any way similar to short-term general hospital patients; we therefore believe there is no basis for paying for such cases using the IPPS methodology.

f. The Proposed SSO Reimbursement Methodology Ignores the Normal Statistical Distribution of Patients' Lengths of Stay

The short-stay outlier reimbursement methodology proposed by CMS in the January 2006 Proposed Rule ignores the normal statistical distribution of patients' lengths of stay across a continuum that includes patients who stay less than the geometric mean length of stay as well as those who exceed it. Perhaps the best example of this, at best, oversight, and at worst, bias, is that using the proposed methodology, a DRG 475 patient (which happens to be the most common and prevalent DRG assigned to LTCH patients) who stays in the LTCH facility 26 days would not only be characterized as a short-stay outlier, but would also be reimbursed as if the patient stayed at a short-term hospital for the facility's geometric mean length of stay (which is on the order of 8 days).[6] In addition, the patient,

[5] *See* Table 4 to ALTHA comments to Proposed Rule, March 10, 2006. (Exhibit 2.)

[6] *See* Exhibit 3.

despite being classified as a SSO, would actually have stayed in the LTCH facility for longer than the 25 day length of stay that has been established by CMS as the basic, underlying requirement for LTCH certification. Regardless of the DRG at issue, any suggestion that a patient who stays in a LTCH facility for longer than the qualifying 25 day length of stay (that has been established as a requirement for LTCH certification in the first place) constitutes a SSO case, is simply untenable.

Prospective payment systems are designed to take into account the law of averages; some patients have longer lengths of stay and some have shorter lengths of stay. This is no less true for LTCH PPS than it is for IPPS, or any other PPS system. CMS' Proposed Rule treats SSO data completely outside of the PPS context and concept, and seeks to create a system whereby the guiding principle will be the fundamental law of averages for some patients' stays, but not others. Not coincidentally, to LTCH providers' great detriment, all of an LTCH provider's risk under the SSO payment system is enhanced while the Medicare program's risk is drastically reduced.

FAH believes that such an adjustment is fundamentally unfair; the Medicare program is protected under all circumstances, since overall payments are relatively fixed, whereas an individual LTCH provider, or a company such as Kindred that operates a number of LTCH facilities, is virtually guaranteed under the SSO proposal to be paid less than cost. In this manner, CMS' proposed changes to SSO reimbursement violates Congress' establishment of LTCH as a separate class of hospitals and Congress' and CMS' own understanding of the legislative intent behind the IPPS, LTCH PPS and all other PPS systems.

In its August 2002 final rulemaking establishing LTCH PPS, CMS stated:

> The acute care hospital inpatient prospective system is a system of average based payments that assumes that some patients' stays will consume more resources than the typical stay, while others will demand fewer resources. ...
>
> The Congress excluded these hospitals [LTCHs] from the acute care hospital inpatient prospective system because they typically treated cases that involve stays that were, on average, longer or more costly than would be predicted by the DRG system. The legislative history of the 1983 Social Security Amendments stated that the 'DRG system was developed for short-term acute care general hospitals and as currently constructed does not adequately take into account special circumstances of diagnoses requiring long stays. (Report of the Committee on Ways and Means, U.S. House of Representatives, to accompany HR 1900, HR Report No. 98-25, at 141 (1983).' Therefore, these hospitals could be systematically underpaid if the same DRG system were applied to them.

67 Fed.Reg. 55,954, 55,957 (August 20, 2002).

CMS' new proposal runs contrary to the structure of LTCH PPS. LTCH PPS contemplates a standard payment rate per case for each LTC-DRG. Implicit in this system is the understanding that regardless of whether a patient's length of stay actually exceeds or falls below the average, the payment to the provider remains the same. By setting payments based on averages, incentives for LTCHs to furnish the most efficient care possible to each patient are included, and LTCHs bear the primary

financial risk with respect to patients who exceed the average length of stay for their LTC-DRG. It must be expected, based on the law of averages, that the lengths of stay of approximately half of all LTCH patients will be below the average, and many of these patients will likely be below the "five-sixths" level that CMS has adopted to demarcate SSOs. Payment for these cases based on LTC-DRG rates is completely consistent with the theoretical underpinnings of LTCH PPS. Radically decreasing payment levels for the vast majority of patients whose length of stay is under the average, without increasing the payments for those above the average, is completely contrary to the fundamental structure and presumptions of LTCH PPS.

In an LTCH facility, one expects to find a high frequency of deviation from the average length of stay within a given a LTC-DRG. Where one is dealing with lengths of stay routinely falling in the 20 to 40 day duration, there is likely to be far more "play" in the admission length, in terms of number of days admitted, and far less certainty when the patient is actually admitted, how quickly he or she will progress and precisely what length of acute hospital services will be needed. In contrast, when a patient is admitted to a short-term acute care hospital for a specific procedure or with respect to a specific injury or illness, the degree of predictability is far greater and the likelihood of a stay being several days longer or many days shorter is the clear exception, not the rule. FAH is uncertain to what extent and why CMS does not recognize this fundamental distinction between the IPPS and the LTCH PPS and how application of the law of averages plays out in either type of facility.

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

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

The fact that LTCHs admit many patients who have already received some hospitalization at an IPPS hospital does not mean that those patients have been prematurely or inappropriately discharged from the IPPS hospital. Without more data on the patient's condition and a valid comparison of the respective resources of the LTCH and the IPPS hospital, the only inference that can be drawn solely from the number of patient admissions from IPPS hospitals is that those patients continue to require hospitalization. CMS's logic fails to acknowledge and account for the simple fact that the patients that are most appropriate for LTCH care – that is, the sickest patients with the most medically complex cases – would very likely also have been initially admitted to a general acute care hospital prior to any determination of their appropriateness for LTCH care. The fact that most LTCH patients come from general acute care hospitals actually suggests that LTCH patients are being correctly identified from among the patient population most likely to be appropriate for LTCH admission. FAH believes that the best available data supports the decisions made by medical professionals who determined that certain patients would be better cared for in an LTCH setting, with its greater resources and better trained staff to treat the patients' conditions, than in an IPPS hospital, which must focus on emergencies, surgery, and

more acute episodes of illness than longer term management of the severely and chronically ill. Staffing differences, equipment differences and medical specialty differences will exist when comparing LTCH and IPPS facilities, respectively.

The differences between these types of facilities is best illustrated by an example. The payment rate for LTCHs for a patient who is ventilator dependent (DRG 475) assumes that the patient will stay in the LTCH about 34 days, on average. An LTCH could provide excellent care and discharge such a patient after only 26 days. Under CMS's proposed rule, the LTCH would receive the IPPS hospital payment rate[7] for this patient, which assumes the patient was only hospitalized for about 8 days. This would result in the LTCH receiving far below its actually incurred cost in treating the patient. In fact, a majority of DRG 475 SSO cases in LTCHs have stays well above the typical 8 day short-term general hospital geometrical mean LOS, indicating that CMS proposes to pay less than cost most of the time, an untenable result. A full 11% of DRG 475 SSO cases are discharged within 5 days of the 28.5 day (5/6) threshold, and likely would have costs more similar to the full LTCH DRG payment than the IPPS payment based on an 8 day stay.[8] Such a system creates a disincentive for orderly admission and discharge of IPPS and LTCH facility patients.

4. CMS' Proposal to Pay for SSO Patients at the IPPS Rate Is Inconsistent With the Congress' Directive

By introducing a proposal to pay SSO cases at IPPS rates, CMS appears to disregard the mandate of Congress in establishing LTCHs as a distinct, IPPS exempt hospital provider category. As CMS must be aware, the Social Security Act, Section 1886(d)(1)(B)(iv)(I) defines an LTCH as "a hospital which has an average inpatient length of stay ... of greater than 25 days." Whereas this provision includes the term "average" it must be concluded that Congress fully understood and intended that a significant portion of LTCH patients would experience lengths of stay well below the 25 day certification standard. Otherwise, Congress would have included a "minimum" length of stay of 25 days. Any other inference renders the concept of "average" within the statutory framework, completely meaningless.

By concluding presumptively that SSO patients have been admitted to LTCHs inappropriately and proposing to pay these cases under IPPS methodology, CMS is, frankly, substituting its own will in place of the Congress' will to exempt LTCHs from IPPS. And to make matters worse, CMS is now proposing to pay SSO cases in LTCHs at a level of IPPS reimbursement *that does not include recognition that in an IPPS facility, the case would undoubtedly qualify for high cost outlier status.* Yet, under CMS' proposal, the only outlier payment for which an LTCH PPS SSO case can qualify is an LTCH PPS high cost outlier payment which would, virtually by definition, occur in the same admission as a short-stay outlier most infrequently.

CMS does not avoid the fundamental conflict between its proposal and the statutory LTCH definition by virtue of the regulatory language it uses to implement the new reimbursement policy. The new SSO payment ceiling in 42 C.F.R. § 412.529(c)(2)(iv) is described as "an amount payable under [LTCH PPS] that is *comparable to* an amount that is otherwise paid under the hospital [IPPS] ... (emphasis added)." Use of the words "comparable to" does not negate the actual effect of the proposal –

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[7] Without any IPPS outlier payment.

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

namely, to reimburse LTCH cases at rates developed for IPPS-reimbursed general acute care hospitals. CMS says as much itself when it justifies this policy on its opinion that LTCHs are "behaving like acute care hospitals," even though there is no evidence that LTCHs are failing to meet the 25-day statutory certification standard. CMS' "comparable to" language does not comply with the statutory intent of the legislation establishing LTCHs as a separate provider category.

It follows necessarily from the statutory definition of LTCHs that, as long as the facility satisfies the statutory certification standard – *i.e.*, an average length of stay of greater than 25 days – any patient for whom continued acute care is medically necessary is, by definition, appropriate for LTCH admission.

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

In the Proposed Rule, CMS asserts that SSO cases (*i.e.*, patients whose length of stay is less than the SSO threshold) "most likely do not require the full measure of resources available in a hospital that has been established to treat patients requiring long-stay hospital level services." In this assertion, CMS appears to apply the SSO thresholds in a manner that CMS did not originally intend.

The SSO thresholds were never established to reflect the appropriateness of an LTCH admission. SSO thresholds are simply the mathematical result of the per diem rates that CMS established for cases whose lengths of stay are less than the average for a particular LTC-DRG. CMS explained in the August 2002 Final Rule that the SSO threshold "corresponds to the day where the full LTC-DRG payment would be reached by paying the specified percentage of the per diem amount for the LTC-DRG." By providing for per diem payments until this point, CMS accomplished its objective of "a gradual increase in payment as the length of stay increases, without producing a 'payment cliff,' which will provide an incentive to discharge a patient one day later because there will be a significant increase in the payment." 67 Fed. Reg. 55,996. By setting the per diem rates at 120 percent of the average LTC-DRG specific per diem amount, the SSO threshold necessarily became fixed at 5/6 of the geometric mean length of stay for the LTC-DRG. This relationship between the per diem rate and the SSO threshold is illustrated in the preamble to the March 2002 Proposed Rule. 67 Fed. Reg. 13,454-55. The SSO threshold was simply derived from the per diem payment amounts and had nothing to do with the appropriateness or inappropriateness of admissions of SSO cases for LTCH care.

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

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

In short, the SSO thresholds are not, and were never meant to be, a measure of the appropriateness of an LTCH admission. Implementing a payment policy that assumes that all SSO cases were inappropriate for admission for LTCH care lacks any foundation in supportive data and reflects a misunderstanding and misuse of the SSO thresholds.

6. CMS's Proposal on SSO Cases Conflicts With the Agency's Earlier Analyses of SSO and Very Short-Stay Outlier Cases

CMS appears to have ignored the fundamental principles on which its prior analysis of SSO cases was founded. When CMS first proposed a special payment policy for SSO cases in 2002, under which a LTCH would not receive a full LTCH DRG payment, CMS carefully analyzed the competing considerations, identified numerous available options, simulated the impact of those options using actual data, and then carefully selected a series of three alternatives, the lesser of the three which was to become the payment rule in each SSO case. The upshot of the SSO provisions of the rule as adopted in 2002 was that the aggregate of per diem payments set at 120% of the LTC-DRG specific per diem would equal the full LTC-DRG once a patient's length of stay reached five-sixths (5/6) of the geometric mean length of stay for the particular LTC-DRG (i.e., at that duration the case would no longer be a SSO). CMS, moreover, rejected an approach separately treating for payment purposes "very short-stay" discharges at that same time. *See* 67 Fed.Reg. 56,000. CMS even recognized at the time that adoption of the "very short stay" methodology would inappropriately penalize an LTCH "for those occasions when, in good faith, it admits a patient, who shortly after admission, expires or is transferred to a more appropriate setting." Id.

Now, CMS, after looking at only one complete year of data, and part of another, proposes to radically alter the methodology for determining payment amounts for SSO cases. In stark contrast to CMS' development of SSO payment policy in the March 2002 proposed rule and the August 2002 final rule, and despite the fact that CMS claims numerous times in this Proposed Rule that it has insufficient data to effect a budget neutrality adjustment concerning even fiscal year 2003, CMS' newly proposed SSO policy proposals are based only on CMS' unsubstantiated assumptions that all SSO patients have been inappropriately admitted to LTCHs and/or inappropriately discharged from general acute care hospitals.

C. Recommendations

FAH strongly believes that CMS should *not* revise the payment adjustment formula for short-stay outlier ("SSO") patients as proposed. The changes are not supported by the data presented in the Proposed Rule and herein. Only after CMS has more than one full year of cost report data from the transition to LTCH PPS *and* CMS performs a valid analysis of the facility characteristics, clinically based patient criteria, and resources of LTCHs compared to general short-term care hospitals for the LTCH patient conditions treated will CMS be in a position to understand whether the current SSO

payment methodology is fair. FAH believes it is fair at present. The overwhelming majority of SSO patients are appropriate for LTCH care, based upon clinical admission decisions after applying objective and rigorous clinical screening criteria and comprehensive patient plans of care. IPPS hospitals should not violate their own admitting and discharge guidelines to hold LTCH-appropriate patients for longer in a general acute care hospital setting that is not structured to do so. Likewise, general acute care hospitals should not be reluctant to transfer patients in need of LTCH care to LTCH facilities where the clinical indicators suggest it is in the best interests of the patient. The LTCH PPS, like all prospective payment systems, is based on averages by design – some patients have longer lengths of stay and some shorter. Provided that LTCHs satisfy the statutory requirement of an *average* inpatient length of stay that exceeds 25 days, these hospitals have achieved the desired balance of short- and long-stay patients envisioned by LTCH PPS.

FAH urges CMS to consider alternatives that include clinically based patient criteria to more appropriately target any cases that, based on a meaningful analysis of current data, are likely the result of inappropriate admissions to LTCHs. FAH recommends that CMS consider the following alternatives presented by ALTHA in its March 10, 2006 comments to address the issues raised in the proposed rule regarding SSOs:

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

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

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

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

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

If CMS decides to use payment mechanisms to address SSOs, we recommend that CMS implement a much more targeted approach than the one contained in the Proposed Rule. As noted above, in CMS's March 2002 Proposed Rule, CMS articulated the same concern that has formed the

basis for its current proposal – namely, the potential that some short-stay patients may not have been appropriate for LTCH admission. At that time, CMS proposed to address this concern with a more tailored alternate payment policy for very short-stay discharges. In the August 2002 Final Rule, CMS declined to adopt this policy because it concluded that its concerns were adequately addressed in the broader SSO payment policy. Nevertheless, the very short-stay discharge policy presented in the March 2002 Proposed Rule demonstrates that a more thoughtful and targeted approach to address CMS' concerns is possible. We urge CMS to develop a more targeted alternative payment policy that is tailored to meet any legitimate concerns about inappropriate admissions. Furthermore, any such alternative payment policy must be based on a rigorous and objective analysis of relevant and current data, and must result in payment amounts that bear a relationship with the LTCH's costs of providing care on average for the affected cases.

Specifically, CMS should consider the following alternatives for "very short stay" cases:

a. **Define "very short stay" cases as those with a length of stay well below the mean for all LTCH cases (*e.g.*, 5-7 days) and reimburse those cases at no more than cost.** The rest of LTCH cases that are between the "very short stay" and the 5/6th geometric mean threshold for their DRG would be defined as "short stay outlier" cases, and would be paid under the current "lesser of" payment methodology. Paying no more than cost for the "very short stay" cases removes any incentive that might arguably exist for LTCHs to admit patients who could be predicted to have very short lengths of stay.

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

In summary, CMS has an obligation to slow this process, review all credible data, and make an appropriate choice of policy based on a series of historical data. Under whichever approach that CMS chooses, and whatever percentage of cost that CMS pays for short stay cases, it is vitally important that CMS evaluate the overall adequacy of the LTCH payment system as a whole, with due consideration of how those decisions affect the ability of LTCHs as well as other types of short and long term providers to meet patient care needs.

II. Proposal to Not Update the FY 2007 Federal Rate

A. Proposal To Not Update The RY 2007 Federal Rate

1. CMS' Position is Inconsistent with Congress' Intent and CMS' Policy.

CMS proposes that the LTCH PPS federal rate not be raised for the 2007 Rate Year, and that it be maintained at $38,086.04. CMS bases its recommendation on the analysis of the LTCH case mix index ("CMI") and margins before and after implementation of LTCH PPS and the latest available LTCH cost reports, which purportedly show that LTCH Medicare margins were over 8% for FY 2003

and 11% for FY 2004. CMS' proposal is also consistent with a recent MedPAC recommendation that Congress eliminate the update to payment rates for long-term care hospital services for Rate Year 2007. *See* March 2006 MedPAC Report to Congress: Medicare Payment Policy, page 219. Of note, Congress has not agreed, or at least in any event has not taken action on, any such MedPAC recommendation and has not eliminated an update to the RY 2007 payment rate for LTCH services. In addition, FAH notes that the CMS proposal to not update the RY 2007 federal rate pursuant to the RPL Market Basket update of 3.6% is contrary to longstanding policy and represents a duplicative reduction in payment rates to address a problem that a prior reduction has already accomplished.

B. The 3.6% Update Should Be Applied

1. The Basis of the Proposal to Not Update the RY 2007 Federal Rate is Fundamentally Flawed

The case mix index ("CMI") is defined by CMS as an LTCH's case-weighted average LTC-DRG relative weight for all its discharges in any given period. CMS characterizes a change in CMI as either "real" or "apparent". A "real" CMI increase is described by CMS as an increase in the average LTC-DRG relative weights resulting from a hospital's treatment of more resource-intensive patients. CMS describes an "apparent" CMI increase as an increase in CMI resulting from changes in coding practices. CMS suggests that freezing the federal rate for RY 2007 will eliminate the effective coding or classification changes that do not reflect "real" changes in LTCHs' case mix.

CMS bases its conclusions on data provided by the 3M Company, pursuant to a contract with CMS. The 3M analysis looked at FY 2003 LTCH claims data from the first year of implementation of LTCH PPS and compared it to FY 2001 claims data generated prior to the initiation of LTCH PPS. 3M determined that the average CMI increase from FY 2001 to FY 2003 was 2.75%. CMS does not indicate what the precise CMI changes were from FY 2001 to FY 2002, and from FY 2002 to FY 2003. CMS provides only the "average" change. Clearly, if the change from FY 2002 to FY 2003 was greater than 2.75%, this could erode CMS' claim that coding changes between FY 2003 and FY 2004 played a major role in driving up the LTCH CMI between FY 2003 and FY 2004. Yet, CMS assumes from this data that the same 2.75% "real" CMI increase remained constant during the next year or two of LTCH PPS. The 3M data showed a 6.75% increase in CMI between FY 2003 and FY 2004; consequently, CMS concluded that 4.0% of that increase must represent the "apparent" CMI increase resulting from improvements in LTCH documentation and changes in coding practices. Several errors become apparent.

CMS failed to take into account the fact that many LTCHs including FAH member Kindred's (44 facilities) hospitals, did not begin to transition to LTCH PPS until very late, in September 2003, which was only one month before the "second" (fiscal) year of the LTCH PPS transition FY 2004 started. Thus, CMS' assumption that 4% of the 6.75% rise in CMI between FY 2003 and FY 2004 is attributable to better LTCH coding and documentation is unsupported, at least with respect to some portion of the LTCH facilities at issue, including a number of FAH members. The fact that CMS did not look at the latest case mix data from FY 2004 (or later), when all LTCHs in operation at the time LTCH PPS went into effect had already begun the transition to LTCH PPS, makes CMS's conclusions inherently suspect and the data on which they are based, unreliable. In addition, since during the first year of the transition period, the federal rate only made up 20% of an LTCH's payment (for those LTCHs that chose to transition to LTCH PPS over 5 years), it is far less likely that LTCHs were "aggressively coding" LTCH stays during FY 2003 (or 2004 for that matter for those late starters) in a

manner that could account for the entire (or even most of the) differential between the pre-LTCH PPS average CMI increase and the post-LTCH PPS average CMI increase. These false assumptions cannot form the basis for meaningful policy.

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

Second, CMS apparently bases its conclusion not to update the federal rate for RY 2007 on a report by a Medicare Program Safeguard Contractor, working with a fiscal intermediary, that examined a sample of LTCH claims and determined that a majority of those patients were not "hospital level" patients. This conclusion, however, was reached by the Medicare contractor after a single review using only a sample of claims from a single LTCH, and to make matters less credible, in a case where some of the contractor's conclusions were later disputed by a Medicare-contracted QIO. Regardless of whether or not the particular LTCH at issue admitted hospital level patients, to conclude that the entire industry should not get a market basket update based on such sparse and unreliable data, is totally unsupported. FAH members, for their parts, have experienced extremely low (1% to 3% in most cases) denial rates based on QIO review with respect to the medical necessity of their services provided to LTCH patients. That these facilities should be denied their otherwise rightful RPL index based 3.6% update for the federal Rate Year 2007 on the basis of such miniscule and unreliable data involving some other single provider, is arbitrary and capricious and unsupportable as policy.

Without question, QIOs are finding overwhelmingly that LTCH patients have appropriately been admitted and treated in LTCHs. Therefore, a broader examination of the data on QIO reviews contradicts CMS's use of this data in support of a rate freeze for FY 2007.

3. The CMS Analysis of LTCH Margins Is Flawed

The third source of erroneous data discussed in the Proposed Rule as support for the rate freeze is an internal CMS analysis that essentially retraces the steps MedPAC took to examine LTCH margins before and after implementation of LTCH PPS. CMS states that full-year cost report data from FY 2003 indicate that LTCH Medicare margins were 8.8 percent in that year, and preliminary cost report data for FY 2004 show LTCH Medicare margins of 11.7 percent for that year. CMS says that LTCH Medicare margins prior to LTCH PPS (going back to 1996) ranged from -2.2 percent in FY 2002 to 2.9 percent in FY 1997. A closer examination of the MedPAC data on LTCH margins, however, reveals that almost a quarter of LTCHs (23%) actually experienced *negative* Medicare margins in 2004. In addition, MedPAC apparently was unable to take into consideration the effect of the 25 percent rule on reimbursement to LTCH hospitals-within-hospitals for admissions from the host hospital when modeling LTCH Medicare margins. *See* MedPAC Meeting Transcript, pg. 164. FAH must conclude on this basis that CMS has reached incorrect conclusions from the selected observations about LTCHs' Medicare margins to support its proposed freeze of the LTCH PPS federal rate in FY 2007.

In the Proposed Rule, CMS also suggests that since LTCH cost report data does not reflect increases similar to the noted increases in CMI, and whereas the costs reported by providers did not increase as rapidly as reported increases in CMI, LTCHs must be incorrectly coding cases. CMS does not indicate, however, that it is allowing for <u>any</u> increase in efficiency by LTCHs, which would lower costs but not affect CMI. In a different part of the Proposed Rule, CMS suggests that it may begin measuring efficiency and include that in the LTCH market basket methodology. This is inconsistent with CMS' position regarding the increase in CMI. On the one hand, CMS admits that efficiency likely

plays a part in LTCH payment adjustments, yet CMS refuses to concede that efficiency affects cost growth as well as in CMI. In fact, when CMS has discussed PPS transition periods in the past, the agency stated its expectation that providers will become more efficient under a PPS system. It is erroneous, therefore, for CMS now to take a contrary position, and ignore its own stated expectations and the available data, to conclude that LTCHs transitioning to LTCH PPS will somehow not become more efficient for purposes of measuring CMI growth.

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

CMS also has failed to consider the re-weighting of LTC-DRG rates earlier this fiscal year. CMS does not discuss in the Proposed Rule the impact that the re-weighting of LTC-DRG rates earlier this year had on LTCHs' CMI since the implementation of the LTCH PPS. In fact, in large part if not completely, CMS has already corrected any coding issues from 2004 by re-weighting the LTC-DRG rates in its final IPPS rule for FY 2006, published in August 2005. Therein, CMS reduced the LTC-DRG rates (resulting in an agency estimated 4.2% reduction in payments to LTCHs) for the exact same reason that CMS now proposes to apply no market basket update for RY 2007, that is, because PPS reimbursements to LTCHs were higher than LTCH costs in 2004, according to CMS calculations. In its 2006 IPPS rule, CMS stated the following rationale for reducing the LTC-DRG rates for FY 2006:

> As we explained in the FY 2006 IPPS proposed rule (70 FR 23667), we continue to observe an increase of relatively lower charge cases being assigned to LTC-DRGs with higher relative weights in the prior year. The addition of these lower charge cases results in decrease in many of the LTC-DRG relative weights from FY 2005 to FY 2006. This decrease in many of the LTC-DRG relative weights, in turn, will result in an estimated decrease in LTCH PPS payments. As we explained in that same proposed rule, contributing to this increased number of relatively lower charged cases being assigned to LTC-DRGs with higher relative weights in the prior year were improvements in coding practices, which are typically found when moving from a reasonable cost based payment system to a PPS. . . .
>
> As we discuss above, we believe that there are no systemic errors in the LTCH FY 2004 MedPAR data, and we believe that the increase of relatively lower charge cases being assigned to LTC-DRGs with higher relative weights that we observed in the FY 2004 LTCH claims data . . . accurately represents current LTCH costs . . . Therefore, because we believe the FY 2004 claims data used to determine the FY 2006 LTC-DRG relative weights accurately reflect the resources used by LTCHs to treat their patients, and these data show either decrease in the average charge of the LTC-DRG or an increase in the average charge of the LTC-DRG that is less than the overall increase in the average charge across all LTC-DRGs, we believe that the decrease in many of the LTC-DRG relative weights is appropriate. . . . Therefore, we continue to believe it is appropriate to base the FY 2006 LTC-DRG relative weights on LTCH claims data in the FY 2004 MedPAR file. . . 70 Fed.Reg 47335 (Aug. 1, 2005).

In this January 2006 Proposed Rule, CMS has essentially documented the same observed phenomenon that it found less than six months earlier, that during the transition to the LTCH PPS, LTCH coding practices resulted in patients being assigned to DRGs with reimbursements that are higher than the LTCH's costs for those patients. CMS eliminated such differences between reimbursement and costs in 2004 by reducing LTC-DRG relative weights in 2006 (and it did the same for 2003 differences in the 2005 LTC-DRG weights). By now eliminating the market basket update in RY 2007, CMS will be correcting the same alleged PPS coding transition problem that it previously corrected in the 2006 IPPS rule. As a result, LTCHs will be unfairly penalized and short-changed a second time for the same reason.

5. CMS Has Just Adopted A New Market Basket Index, Yet Immediately Rejects Its Findings

There is absolutely no basis for CMS not to follow and give effect to its highly touted, new RPL Market Basket Index in the first year of its existence. In the Proposed Rule, CMS discusses the high degree of precision and targeted applicability of the new RPL Market Basket Index, which is specifically targeted to determine the market basket forces that impact the narrow band of providers affected by inpatient rehabilitation PPS, inpatient psychiatric PPS, and long-term care acute hospital PPS. After touting the accuracy and other virtues of the new index and explaining all the many and important reasons to substitute this new index (which calls for a 3.6% update for RY 2007) in place of the previous index, CMS then abruptly shifts gear and states that despite the findings of its new market basket index, and notwithstanding the existing regulatory mandate for a market basket update, CMS now proposes to amend its regulation and eliminate the 2007 market basket update based on the RPL Market Basket Index. CMS's proposal is unfounded, inconsistent and contrary to its own development in this year of the new RPL Market Basket Index.

CMS should go forward and apply the 3.6% market basket update as called for by its own newly developed market basket index.

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

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

C. Recommendations

FAH supports the recommendations submitted by ALTHA in its comments to the Proposed Rule, submitted March 10, 2006. CMS should allow a full RPL Market Basket Index update to the LTCH PPS federal rate for FY 2007. Projected or assumed "overpayments" in the LTCH system are

effectively eliminated from the payment system on an annual basis as CMS recalibrates the LTC-DRG weights or makes similar adjustments to other aspects of the LTCH PPS.[9] CMS has achieved complete and up to date payment adequacy through the DRG re-weighting. A zero market basket update would be a duplicative and unnecessary cut in LTCH payments to address the very same issue that CMS just addressed in the IPPS Final Rule for FY 2006. CMS also needs to account for other changes in LTCH coding, including the amended guidelines regarding classification of patients under DRG 475, when proposing changes to the update.

III. Monitoring/RTI International Study

A. The Study

CMS summarizes the preliminary data analyses conducted by its contractor the Research Triangle Institute International ("RTI") and indicates that its purpose is to analyze the LTCH provider category and determine the feasibility of implementing MedPAC's recommendations (in the June 2004 Report to Congress) for creating new LTCH facility and patient criteria. CMS states that such criteria would help assure that patients admitted to LTCHs are appropriate for the LTCH level of care. The RTI research is designed to:

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

The RTI study is primarily based on analyses of the 100% MedPAR 2003 file, other Medicare data, stakeholder interviews, and site visits to LTCHs.

B. The Methodology Is Not Adequately Described

FAH believes that CMS has not adequately described in the Proposed Rule the methodology that RTI is and will be using to analyze LTCH data. Absent an understanding of RTI's methodology, FAH cannot provide meaningful comments or a focused response to the preliminary data analyses that are superficially described in the Proposed Rule. CMS needs to explain RTI's methodology.

C. RTI's Analyses Do Not Explain the Causes of Industry Growth

CMS identifies that one of its goals "is to determine whether this [increase in numbers of LTCHs] is due to growing patient demand or industry response to generous payment policies." Yet, no reported data indicate that RTI has seriously or ever studied this issue. It is not possible for FAH to submit meaningful comments until such time as CMS publishes results that address this issue. The

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9 Recalibration and re-weighting, if done in a budget neutral manner, effectively adjusts payments more fairly across DRGs. *See also*, footnote 13, page 26.

assertion that LTCHs have increased in numbers exponentially" is not mathematically correct, nor is it meaningful without context. In what way, since when, and in what markets, are just three of the important questions that must be asked. For example, by RTI's own findings, in many places around the United States, Medicare beneficiaries still do not have access to LTCHs. Finally, FAH notes that despite CMS' concern over perceived increases in the number of LTCH facilities, CMS Medicare spending for LTCHs is estimated to be only about 1% of total Medicare spending.[10]

D. The Proposed Rule Lacks A Full Discussion of How To Measure Patient Outcomes

CMS confirms that the "central question" of the research by RTI is to determine "whether there is a correlation between the higher payments at LTCHs and improved patient outcomes for the same types of patient in different treatment settings." But in the Proposed Rule, CMS offers no data that compare outcomes for clinically identical patients across the continuum of post-acute care providers; thus, FAH members of different types are not furnished a meaningful opportunity to comment on this section. The only published outcomes data point concerns mortality rates for LTCHs and short-term hospital outlier patients for a subset of patients (short-term hospital outlier mortality rates in that sample were about one-third higher than the rate for LTCH patients). Regardless, the RTI comparison of acute outlier patients with LTCH patients does not address similar patients' outcomes across different settings. Thus, the most critical issue that RTI's research is to address has not been discussed. The appropriate comparison of outcomes would necessarily analyze a subset of clinically similar patients that have been discharged from general acute hospitals to SNFs, IRFs, IPFs, home health, and LTCHs.

FAH squarely rejects the notion that the principal, or even a proper, measure of outcomes is costs per case, which seems to be an implied outcomes measure in the RTI study methodology, *without controlling for patient acuity*. For example, on page 4,710 of the Proposed Rule, RTI reveals that the cost per case for LTCH patients in DRG 462 was $20,311 while the IRF payment in a majority of cases is $11,741. RTI then states that "little is known about the differences in severity across the different settings." Patient acuity differences are the key variable that the Medicare PPS payment methodologies address in adjusting payment amounts both through DRG weights and through differences in Federal base rate amounts. If there has been no meaningful analysis of patient acuity, RTI's comparison of the costs per case among different provider types has little value.

E. RTI Does Not Adequately Describe LTCH Patients

According to the Proposed Rule, one major focus of the RTI study is to identify and describe the differences between LTCH patients and those seen in other post-acute settings. RTI's assessment of acute outlier and LTCH patients does not resolve this issue. RTI reports that LTCH patients tend to have a higher number of co-morbidities relative to other types of post acute care providers and this is certainly not surprising to FAH. Also, RTI evaluated medical complexity by using Hierarchical

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[10] In the proposed rule, CMS estimates FY 2007 spending for LTCHs to be $5.27 billion (see 71 Fed. Reg. at 4,681). This figure excludes an SSO policy effect of 11.1% and includes a market basket update of 3.6%. By reducing the $5.27 billion by the CMS-estimated 11.1% SSO policy effect, and by eliminating the market basket update, spending under existing policies would be $4.5 billion in 2007. CBO estimates of net mandatory Medicare spending in FY 2007 is $383.4 billion, meaning that LTCH spending projections equal 1.2% of net mandatory Medicare spending. If you assume, as does CMS, that the 11.1% estimated reduction for the proposed changes to SSO payments does not occur, LTCH spending is projected to be just 1.3% of net mandatory Medicare spending in 2007.

Coexisting Condition ("HCC") scores, which are based on a patient's Medicare expenditures from the year preceding the index IPPS admission. Overall, "LTCH only" patients had the highest average HCC score of any post-acute care provider, according to the RTI data. Again, this is precisely what FAH would expect to see: LTCH patients are severely ill and medically complex.

FAH also notes that a major LTCH provider trade association, ALTHA, in collaboration with LTCH providers, conducted an evaluative study of the LTCH provider community with a focus on patient and facility level characteristics. This study, reported on in ALTHA's Comments to the Proposed Rule of March 10, 2006, builds on previous work performed to identify and recommend appropriate LTCH certification criteria. . ALTHA's data shows that the vast majority of LTCH patients are classified in the highest APR-DRG SOI categories[11] – regardless of whether one is looking at all LTCH cases, just the five most frequent "short stay" outlier DRG cases, or all "short stay" LTCH cases – but that only a third of short term care hospital patients are classified in the highest SOI categories (*See* Table 4 to ALTHA March 10, 2006 Comments - "LTCH Patients are Much Sicker than Average Short Term Hospital Patients" at Exhibit 2). This supports the conclusion that LTCH patients are, in fact, much sicker than short term hospital patients, and that they comprise a different population of patients with different needs than general acute care patients. To force general acute providers to treat a great number of LTCH patients or LTCH providers to treat general acute patients makes no sense, medically or economically; thus, regulatory payment policies should not be directed at attaining such a result.

ALTHA also compared patients in LTCHs and short term care hospitals using the APR-DRG "risk of mortality" categories (see ALTHA Table 4 titled "LTCH Patients Have a Higher "Risk of Mortality" than Average Short Term Hospital Patients" Exhibit 2). The Table shows that approximately half of all LTCH cases and half of all "short stay" LTCH cases are classified in the highest APR-DRG "risk of mortality" categories, yet only about a quarter of all short term care hospital cases are classified in this manner. Therefore, LTCH patients are much more likely to expire during their hospital stay than short term care hospital patients. But, such a result does not mean LTCH patients should not be treated in LTCH facilities. Rather, it means that an appropriate payment mechanism has to be developed to address at least those patient deaths occurring in the very early stages of an admission.

Indeed, the acute care hospital MedPAR[12] file shows that cases discharged to LTCHs frequently have a higher SOI than other acute patients discharged to SNFs or IRFs. Sixty-nine percent of patients discharged to LTCHs have a major or extreme risk of mortality during their acute hospital stay, compared to less than half of SNF patients and only 36 percent of IRF patients. (*See* Table 5 to ALTHA comments March 10, 2006; Exhibit 5.) Again, the data show that other types of providers would be ill-equipped to treat these patients.

F. Recommendations

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

12 Data taken from MedPAR 2004, December and March updates.

FAH supports the stated goals of the RTI study: analysis of patient demand for LTCH services, analysis of patient outcomes in LTCHs as compared to other post-acute settings, and research to assess the feasibility of developing certification criteria. FAH supports the work that MedPAC and RTI have conducted in the development of certification criteria and look forward to a continued dialogue with these research organizations. FAH believes that, rather than slowing LTCH spending through payment policy, which is unfocused and imprecise, CMS should work with the industry to implement certification and patient admission criteria to achieve its goals.

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

In section V.B. of the Proposed Rule, "Special Payment Provisions for LTCH Hospitals within Hospitals and LTCH Satellites," CMS describes its concern and possible OIG investigation of the proliferation of freestanding LTCHs. The growth of freestanding LTCHs is stated to have occurred since implementation of the CMS policy restricting admissions (or at least the reimbursement therefor) to an arbitrary percentage from the host hospital to the hospital within hospital ("HIH"). CMS' concern is based on an as yet unproven assumption that LTCHs demonstrate their separateness from host hospitals by admitting a majority of their patients from non-host providers. FAH, however, is aware of no evidence that the percentage of patients admitted to an LTCH from a host hospital correlates to separateness or lack thereof. Many HIHs are owned and operated by FAH member national proprietary chains and are, by definition, separate from their locally owned and operated (and frequently not for profit) hosts.

CMS now trains its sights on the perceived unexplained growth of freestanding LTCHs. CMS appears to believe that if a freestanding LTCH admits a high percentage of patients from a single short-term acute care hospital, that fact, and that fact alone, suggests that the two providers are likely to be gaming or defrauding the system somehow and should therefore be subject to some type of investigation or payments restriction. CMS fails to consider, however, that small sized, specialized LTCHs, freestanding or otherwise, solely for excellent clinical reasons, are likely to establish relationships with large tertiary care centers. Those tertiary care centers are where the sicker patients are, and it is those patients who will most likely require long term care hospitalization. Large tertiary care centers are therefore likely to dominate the number of referrals to a smaller LTCH. This is not some type of collusion or gaming, it is simply the arithmetic of the community in which the LTCH and the large tertiary care provider are located. FAH continues to believe that any reasonable concerns held by CMS about the appropriateness of admissions to LTCHs can best be addressed by reasonable clinical admission criteria.

FAH agrees that every effort should be made to assure that patients are not inappropriately transferred to any LTCH (HIH or freestanding) to maximize Medicare payments. There appears to be no need, however, for CMS to expand or otherwise apply the HIH 25% rule to freestanding LTCHs to achieve this objective.

First, there is no evidence that short-term acute care hospitals are discharging patients to HIHs, freestanding or otherwise, prior to the geometric mean DRG length of stay. This suggests that no specific attempt is being made to assure early IPPS discharge and a higher level of LTCH usage.

Second, the mere fact that many large hospitals are the primary sources of patients for specific LTCHs should not come as any surprise or be troubling to CMS. Generally, patients and their families

want to stay within a certain community or neighborhood for their care. To the extent a LTCH is providing high quality services, why should a local physician or general acute care hospital placement office not seek admission where necessary to that particular LTCH within the same community?

It should also come as no surprise to CMS that any particular LTCH, in any one community, receives the bulk of its patients from one or two large hospitals in the area. The demographics of hospitals have changed markedly over the past decade or so. Many hospitals have closed and/or consolidated; in some parts of the country there are only larger hospitals within any given community. Where an LTCH is located in such a community or part of a larger city, it is likely the closest quality LTCH to the large hospital from which it gets a majority of its patients. There is absolutely nothing inappropriate about such referrals, provided the patients who are being admitted through such referral source are appropriate candidates for LTCH admission, which FAH and its members certainly believe they are in its own case. As stated above, FAH member operated facilities have experienced very low denial rates based on CMS contracted QIO reviews of their admissions.

In addition, it is somewhat illogical to think that a freestanding LTCH can be characterized as a unit of a separate hospital. On this basis, CMS cannot credibly claim that expanding the HIH 25% rule to freestanding LTCHs is supported by the policy reasons discussed in the Proposed Rule.

Furthermore, until the transition period for the HIH 25% rule is completed for all LTCH HIHs (between October 1, 2007 and September 30, 2008), CMS will not be in a position to know whether this HIH payment adjustment is achieving the stated policy goal within having the desired effect on patient care. For this reason as well, it would be unwise and unsupported to extend the HIH restriction to freestanding facilities.

V. Postponement of One-Time Budget Neutrality Adjustment

A. CMS' Proposal Is Contrary To Statutory Authority

CMS proposes to extend its option to exercise a one-time budget neutrality adjustment to the LTCH PPS rates as set forth in 42 C.F.R. § 412.523(d)(3) for two additional years. Pursuant to the regulation, CMS may implement a one-time adjustment no later than October 1, 2006 so that "any significant difference" between actual payments and estimated payments for the first year of the LTCH PPS would not be perpetuated in the LTCH PPS rates for future years. According to CMS' own words, CMS intends to implement this adjustment only for the purpose of assuring budget neutrality in the first year (FY 2003) of LTCH PPS.[13] Yet, CMS now proposes to extend the window for the potential one-time adjustment until July 1, 2008 – nearly two years beyond the deadline originally established in the final LTCH PPS rule and nearly one year after the industry's 5-year transition to LTCH PPS is complete.

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13 The FAH does not believe there is any statutory support for CMS's view that when Congress required that the LTCH PPS system "shall maintain budget neutrality," such requirement was only concerned with budget neutrality when compared to first year payments under the system. Congress clearly understands the concept of budget neutrality in the context of a PPS system and like IPPS, budget neutrality is a moving target given that it should be compared to the amounts that would have been paid under the prior system in any current year. That is why Congress required that budget neutrality would be maintained "for the system" without any reference to a time limitation.

FAH believes the proposed postponement of the deadline for CMS' potential one-time prospective adjustment constitutes an abuse of its statutory authority. CMS should withdraw its proposal in the final LTCH PPS rule for RY 2007, and either make or not make whatever adjustment is needed, if any, to assure budget neutrality in FY 2003, by October 1, 2006.

Pursuant to section 123(a)(1) of Public Law 106-113 (BBRA of 1999), as amended by section 307(b) of Public Law 106-554 (BIPA of 1999), the Secretary "may provide for appropriate adjustments to LTCH PPS" in order to maintain the budget neutrality of the program. Consequently, CMS established by regulation the option of making a one-time prospective adjustment to the LTCH PPS rates to ensure that any errors in the original budget neutrality calculations for the first year (FY 2003) of the LTCH PPS would not be carried through in subsequent rate years. CMS established an October 1, 2006 deadline for this option.

CMS asserts in the proposed LTCH PPS rule for RY 2007 that it presently lacks sufficient data with respect to FY 2003 such that it can reasonably decide whether to impose the one-time rate adjustment. Nonetheless, CMS also states that its "most complete full year of LTCH cost report data are from FY 2003" – the very year in which the original budget neutrality calculations were made and the same year the LTCH PPS was implemented. 71 Fed. Reg. at 4683. By its own admission, CMS has the data it needs to correct for potential errors, if any, in the original budget neutrality calculations. However, CMS then proceeds to suggest "that for cost reports for providers on August 2004 fiscal year ending date, [CMS] would be in possession of the most reliable cost report data indicating the actual costs" of the LTCH PPS in its first year, FY 2003. 71 Fed. Reg. at 4684. If on the one hand, CMS believes that the most complete year of LTCH cost report data is FY 2003, and the year for which any calculation errors should be corrected is also FY 2003, it is at best unclear why CMS on the other hand believes it necessary to obtain more "reliable" cost data for FY 2004 before deciding whether to impose the one-time adjustment. The purpose of the adjustment is to assure budget neutrality is achieved in FY 2003, so that no errors in FY 2003 estimates will get passed on from year to year.

FAH believes that postponing the deadline for the one-time prospective adjustment would therefore be arbitrary and capricious. The postponement of the deadline would allow CMS to wait until "any significant difference" arises in the aggregate to trigger the one-time adjustment, regardless of whether the cost data for FY 2003 actually justifies such an adjustment or not.

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

CMS should withdraw its proposal to extend the deadline for exercising a one-time prospective adjustment.

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

A. The Proposed Changes

CMS proposes several changes to its current policy for calculating high-cost outlier payments to LTCHs, beginning at 71 Fed. Reg. 4,674. CMS is considering a revision to § 412.525(a)(4) to specify that, for discharges on or after October 1, 2006, the fiscal intermediary may use a Statewide average CCR (established annually by CMS) if, among other things, a LTCH's CCR is in excess of the LTCH CCR ceiling. The LTCH CCR ceiling would be calculated as 3 standard deviations above the corresponding national geometric mean CCR. In conjunction with this change, CMS states that it will change its methodology for calculating the applicable Statewide average CCRs under the LTCH PPS to be based on hospital-specific "total" CCRs. CMS also plans to codify the remaining LTCH PPS high cost outlier policy changes that were established in the June 9, 2003 IPPS high cost outlier final rule (68 Fed. Reg. 34,506).

B. FAH Believes That More Information About The Effects Of The Proposed Changes Is Required

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

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

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

C. Recommendations

FAH assumes there will be some effect on LTCHs in making the change to a "total" CCR. CMS should present the data from its analysis of this change so that LTCH providers understand how they will be impacted by this proposal. FAH cannot assess this proposed change unless CMS furnishes a detailed example of the new methodology and provides data on the impact to LTCHs. CMS may want to consider implementing these changes using identical language as in Transmittal A-03-058 (Change Request 2785; July 3, 2003), which contained instructions regarding the changes established in the June 9, 2003 IPPS high cost outlier final rule for both LTCHs and general acute care hospitals.

VII. High-Cost Outlier Regression Analysis

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

FAH opposes action by CMS at this time to revisit the regression analysis for the 80 percent marginal cost factor. First, the LTCH PPS is still relatively new. Continued adjustments such as this only contribute to uncertainty regarding payment for services. The underlying reason for the dramatic change in the fixed loss threshold for FY 2007 is the extremely large 11 percent cut in LTCH SSO reimbursement that CMS has proposed.

Second, FAH agrees with CMS' comments that keeping the marginal cost factor at 80 percent and the outlier pool at 8 percent "better identifies LTCH patients that are truly unusually costly cases" and that such policy "appropriately addresses outlier cases that are significantly more expensive than non-outlier cases, while simultaneously maintaining the integrity of the LTCH PPS." 71 Fed. Reg. at 4,678.

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

The LTCH PPS should strive for stability, particularly with regard to the most costly LTCH patients. These are the high-cost outliers. CMS should be extremely cautious about making changes to the factors that affect high-cost outlier payments to LTCHs – particularly the marginal cost factor and outlier pool percentages established by regulation. FAH believes any such change would be premature at this time.

VIII. SSO Fixed Loss Threshold

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

FAH opposes action by CMS at this time to utilize a fixed loss threshold for SSO cases that is tied into the IPPS. The fixed loss threshold used under the IPPS was developed utilizing analyses that

are unrelated to LTCH PPS and address providers d[illegible]ated and with different needs than LTCH providers. To calculate future payments to LTCH using IPPS reimbursement variables is improper and inappropriate. The IPPS fixed loss threshold was not developed with the resources consumed in the care of an LTCH high cost outlier patient in mind The systems should be maintained as separate. In addition, CMS does not furnish the data necessary to substantiate the use of IPPS fixed loss thresholds as a means of reimbursing LTCH high cost patients.

All aspects of the LTCH PPS should be driven by factors directly related to LTCHs and the cost of caring for patients in these facilities, including the most costly LTCH patients, high-cost outliers. As previously suggested regarding potential adjustments to the marginal cost factor and outlier pool percentages, CMS should be extremely cautious about making changes to the factors that affect high-cost outlier payments to LTCHs. FAH recommends that CMS maintain the existing regulation governing payments related to high cost outliers at 42 C.F.R. § 412.525(a).

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

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

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

Despite the fact that CMS lays out, through conceptual equations and an illustrative example, how the agency might calculate a market basket update, CMS's description of the new methodology remains fairly general. For example, CMS does not define terms such as "real costs" and "real payments" (Equation 7, pg. 4,744) or describe how "real costs" are different from the "costs" concept used in other equations. Further, CMS does not state how it would calculate these concepts. For example, CMS only roughly defines how the agency would calculate "intensity" and introduces new concepts such as cost-effectiveness when it describes "intensity". FAH would be pleased to work with CMS as it refines the data sources it proposes for each market basket concept; thus, FAH reserves comment on these concepts until CMS provides additional information.

FAH is also concerned, however, that some inputs into this new methodology appear to be subjective and solely at the discretion of CMS. For example, CMS suggests using "policy considerations" as well as cost report data in constructing this new market basket update methodology:

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

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

FAH is also concerned about CMS' proposal to include in this new market basket methodology a case-mix creep adjustment (the sum of "apparent" and "real" case mix changes, or the approximate 4% reduction CMS is proposing elsewhere in this Proposed Rule as a basis for not providing a market basket update for RY 2007). However, CMS at least acknowledges that such an adjustment may not be necessary due to the LTC-DRG reweighting that CMS performs annually in the IPPS rule: "[w]hether a LTC–DRG reclassification adjustment would be necessary in the update framework would depend on the data availability and the likelihood of revisions to LTC–DRG classifications on a periodic basis." 71 Fed. Reg. at 4,746. CMS therefore acknowledges that the case-mix adjustment it is proposing this year and would propose under this new methodology is redundant to the LTC-DRG reclassifications (reweighting) it does each year on a non-budget neutral basis in the IPPS rule (which result in a decrease in payments of 4.2% in FY 2006), and a proposed zero market basket update worth 3.6% for RY 2007 for LTCHs. It is thus uncertain what CMS actually is proposing to include in the new update methodology.

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

X. CMS Failed to Accurately Complete the Regulatory Impact Statement

FAH also finds that CMS's Regulatory Impact Analysis (the "RIA") of the Proposed Rule is insufficient. The RIA purports to rely on data that FAH believes cannot justify the Proposed Rule. Pursuant to statute and executive orders, an RIA is required for the purpose of examining the impact of a proposed rule on small businesses, rural hospitals, and state and local governments. A RIA must also give the public a sense of a proposed rule's anticipated monetary effect on the Medicare program and, more importantly, an estimate of the impact on the public's access to and the quality of, care provided to Medicare beneficiaries.

In this case, FAH believes that the RIA is insufficient and questionable on the basis that it purports to analyze the impact of the RY 2007 rule's <u>other</u> proposed changes – which themselves are based on superficial and questionable analyses and data. As discussed above, CMS's proposed 11.1 percent decrease in LTCH PPS payments for FY 2007 was determined in part by comparing LTCH admission patterns for SSO patients in FY 2004 to those in FY 2003. CMS asserts that it looked at changes in SSO percentages over a three-year period; however, a comparison between FY 2003 and FY 2004 constitutes clearly the analysis of a change from only one year to the next. Moreover, FY 2004 was only the second year of the transition period to full prospective payment and thus is not reflective of general "trends" in the LTCH industry, since many LTCHs continued to be paid 60 percent of their reimbursement based on costs in FY 2004.

Consequently, the data underlying the RIA does not reflect real effects in RY 2007. The proposed 11.1 percent decrease in LTCH PPS payments thus is based upon unreliable data and analyses, and the projections set forth in the RIA are likely conjecture at best. FAH believes these factors hinder its members' ability to evaluate, meaningfully comment, and rely upon CMS' RIA.

It also calls into serious question CMS' likely unreliable indication that it does not "expect any changes in the quality of care or access to services for Medicare beneficiaries under the LTCH PPS." 71 Fed. Reg. at 4,738. CMS proposes a 11.1 percent overall decrease in LTCH PPS payments; this further fails to take into account a zero percent increase to the LTCH PPS federal rate and other proposed payment changes. It is difficult to understand how CMS believes that such a monumental shift in payment will have no impact on the quality of patient care industry-wide. CMS' belief that the 11.1 percent decrease "would only occur if LTCHs continue to admit the same number of SSO patients" is predicated on an assumption that LTCHs can accurately predict an individual patient's length of stay. 71 Fed. Reg. at 4727. FAH and others have already shown that such predictions are not possible especially if current good LTCH practices are maintained.

From a clinical perspective, as discussed above, there are no discernable differences between "short-stay" LTCH patients and longer-stay LTCH patients. Physicians who make admission decisions cannot and should not be asked to predict in advance the length of stay for this small subset of medically complex, severely ill patients. In addition, many patients admitted to LTCHs are admitted there after extended stays at acute care hospitals, making it even more difficult to predict how long they will stay in the LTCH, or overall. An 11.1 percent decrease in LTCH payments alone would very likely affect patient care; however, if CMS' implied recommendation that LTCHs should predict in advance how long each patient will stay is actually followed by LTCHs, such misguided patient care decision-making will likely result in an adverse impact on quality of care and access to services for this severely ill population of Medicare beneficiaries.

Importantly, CMS' RIA also fails to take into account the questions of cost, access to care, and quality of patient care affecting general acute care or "shorter stay" hospitals in areas where there are LTCH facilities. Clearly, if CMS' proposals are adopted and LTCHs are "encouraged" not to admit potential patients who may not make it to the point CMS considers to be 5/6 of the geometric mean length of stay for that patient DRG, the severely ill, fragile patients not admitted by LTCHs will have to be treated in some hospital-level provider. This is very likely to be a general acute care hospital, and one that is neither structured nor staffed to house and care for a large number of long-term care patients. This will affect access to care for other needy (shorter term) patients, will force general acute care hospitals to make extremely difficult admission and retention decisions and will likely place brutal cost pressures on general acute care providers. The end result is not likely to be a positive influence on health care quality and access. Yet, CMS includes no discussion of these very likely and palpable effects in this Proposed Rule.

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

To make matters more difficult, recent revisions to the guidelines for utilizing DRG 475 ("Respiratory System Diagnosis with Ventilator Support") have resulted in further reduced payments to

LTCHs. As a result of these separate changes, LTCHs now receive lower payment for treating patients with certain types of respiratory distress, despite that the same resources are being expended on such patients. CMS does not consider this change in the applicability of DRG 475, in which many LTCH cases are classified, in discussing whether the currently proposed payment reductions for RY 2007 will have any net effect on patient care.

FAH contends that CMS' conclusion that it does not "expect any changes in the quality of care or access to services for Medicare beneficiaries under the LTCH PPS" is unreliable and undocumented. CMS should reevaluate the regulatory impact of the Proposed Rule in light of the relevant factors discussed above and issue a revised RIA in a new proposed rule for comment.

XI. CMS Has Failed To Comply With The Data Quality Act, OMB Guidelines, HHS Guidelines AND CMS Guidelines

CMS proposes to make numerous, substantive changes to LTCH payments in the Proposed Rule based on certain identified and unidentified data sources. These data do not support the alteration of payment obligations under LTCH PPS for the reasons stated below.

CMS has used several erroneous items of information that must be corrected concerning the costs and patient characteristics of LTCHs. The erroneous information violates the Federal Data Quality Act ("DQA") [Public Law 106-554, amending the Paperwork Reduction Act, 44 U.S.C. Section 3501, et seq.], the implementing guidelines issued by the Office of Management and Budget (OMB Guidelines) [67 Fed. Reg. 8452, Feb. 22, 2002], HHS Guidelines and CMS Guidelines for Ensuring the Quality of Information Disseminated to the Public, available at www.hhs.gov/infoquality. Pursuant to Section 515 of the DQA, FAH seeks the revision of erroneous data relied upon and disseminated by the Secretary of HHS and the Administrator of CMS in the formulation and publication of the Long-Term Care Hospital Prospective Payment System ("LTCH PPS") payment rates and policies for fiscal year 2007 (July 1, 2006 through June 30, 2007).

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

Pursuant to the DQA, OMB published guidelines in the Federal Register on February 22, 2002. In these Final Guidelines, OMB called upon federal agencies to issue their own implementing guidelines. On September 30, 2002, HHS announced that its guidelines implementing the OMB Guidelines would be available on the internet. As directed by the HHS Guidelines, CMS then issued agency-specific guidelines that bear on this Proposed Rule. The following information is subject to the CMS Guidelines:

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

(2) Statistical or actuarial information;

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

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

The program information subject to the CMS Guidelines includes program information, statistical data sets, research and evaluation reports, technical reports, and payment updates. Several of these types of program information were used and presented by CMS in developing and presenting the Proposed Rule.

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

FAH believes that CMS has not thoroughly reviewed the data it cites as support for the changes to LTCH payments in the Proposed Rule that are discussed in these comments, above, nor does FAH believe that CMS has properly ensured the quality of the those data, also for the reasons discussed above. Before CMS can issue a proposed rule that can stand for meaningful comment, CMS must utilize and review more complete data sets, conduct a proper and thorough analysis of those data, and reach supportable conclusions for its proposed changes to LTCH payments that are not the product of broad, untested and erroneous assumptions. To date, CMS has failed to demonstrate that its data meet the standards established by the CMS Guidelines of utility, objectivity, integrity, transparency, and reproducibility.

First, CMS states that "[U]tility involves the usefulness of the information to its intended users" and that [U]tility is achieved by staying informed of information needs and developing new data, models, and information products, where appropriate." CMS Guidelines at Section V.(A). The utility of the data used by CMS in developing the Proposed Rule and its payment changes for LTCHs fails to meet the required standard. CMS has relied on FY 2003 data for various purposes associated with LTCH PPS even though many of the affected providers, including some FAH member providers experienced their first full year on LTCH PPS in FY 2004. Therefore, CMS' assumptions concerning the alleged 4.0% of the alleged 6.75% rise in the CMI from FY 2003 to FY 2004 being attributable to coding changes is simply unsupported, at least with respect to those facilities whose first full LTCH PPS year was in FY 2004. This clearly impacts CMS' proposal to eliminate the market basket update.

Second, the CMS Guidelines state that "[o]bjectivity involves a focus on ensuring that information products are presented in an accurate, clear, complete and unbiased manner." Id., Section V.(B). "Objectivity is achieved by using reliable data sources and sound analytical techniques, and carefully reviewing information products prepared by qualified people using proven methods." Id. Each of the data issues and erroneous assumptions discussed in these comments indicate that CMS has not maintained objectivity in developing or presenting the Proposed Rule. CMS has conducted only cursory analyses of several key points, has used limited (and severely biased) data sets and has failed to note effects from past data sets in reaching consistently biased assumptions. CMS also failed to consider key data that was readily available to it. For example, CMS cited a single review by a Medicare program safeguard contractor and other anecdotal information about LTCH reviews in

formulating its assumption that many LTCH patients should not be in a hospital. Also, CMS failed to consider data from its own contracted studies concerning the lengths of stay and payment amounts relating to the most common LTCH PPS DRG code (DRG 475).

Finally, CMS did not study at all the impact that the Proposed Rule would have on patients' clinical outcomes or the overall cost of care. It seems that these extremely critical factors would have to be considered as a consequence of the intended purpose of this proposed rule, i.e., that certain patients may no longer be admitted to an LTCH. The quality of care for these patients in alternative settings, and the cost of care in these settings as compared to the cost of care under the existing system, seem to require at least some study by CMS, not just a belief, before this rule proceeds. In short, CMS failed to use reliable data sources, and used extremely limited samples and data sets, or no data at all, in presenting its sweeping and draconian policy changes. CMS has not satisfied its own objectivity standard.

CMS fairs no better under the transparency and reproducibility standards. The policies proposed by CMS will have a substantial public impact, financially and clinically. CMS identifies many sources generally, but often tangentially and CMS' analyses are often not presented. The data and other supporting information are not transparent; thus, FAH and other interested parties are not permitted to test the agency's data and analyses in order to verify the assumptions made by CMS in formulating broad policy changes of great impact. The steps in producing the data, therefore, also cannot be reproduced.

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

A. The APA Requires Rulemaking With Meaningful Comments

The data and analyses relied upon by CMS in establishing the proposed changes to LTCH PPS payments are fatally deficient. FAH and other interested parties cannot offer meaningful comments to the Proposed Rule. Accordingly, CMS must withdraw its Proposed Rule until adequate data is evaluated by the agency and shared with the public. Should CMS choose not to withdraw the Proposed Rule, FAH, as well as other organizations representing LTCHs believe that grounds exist for a court to invalidate the final regulation on the basis of the agency's failure to provide the public with a viable opportunity to offer meaningful comments.

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

The controlling law in the D.C. Circuit is well established and clear. In order for parties to offer meaningful support or criticism under the APA's notice-and-comment rulemaking process, "it is especially important for the agency to identify and make available technical studies and data that it has employed in reaching the decisions to propose particular rules." Connecticut Light & Power Co. v. Nuclear Regulatory Com., 673 F.2d 525, 530-31 (D.C. Cir. 1982). See also Sierra Club v. Costle, 657 F.2d 298 (D.C. Cir. 1981). If the federal agency relies on an outside study in promulgating a rule, the

agency itself must first examine the methodology used to conduct the study. City of New Orleans v. SEC, 969 F.2d 1163, 1167 (D.C. Cir. 1992). Furthermore, the technical complexity of the analysis does not relieve the agency of the burden to consider all relevant factors and there "must be a rational connection between the factual inputs, modeling assumptions, modeling results and conclusions drawn from these results." Sierra Club, 657 F.2d at 333.

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

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

B. Correction of Erroneous Information

FAH joins with ALTHA and other organizations in requesting that CMS withdraw the Proposed Rule and revise the data it is using to develop final payment changes for LTCHs in FY 2007 to correct the flawed and incomplete data discussed above. In doing so, CMS should consider the data submitted herein, revise its assumptions and conclusions accordingly, and publish a new proposed rule.

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

C. Public Notice of Correction

Due to the numerous data errors discussed above, the Proposed Rule is fatally flawed. CMS has asked for comments to the Proposed Rule by March 20, 2006 and has stated that it will issue a final rule on LTCH PPS for FY 2007 in the Spring of this year. Therefore, there is considerable urgency for CMS to evaluate the data issues and additional data and other information provided in these comments before a final rule is published. CMS should correct the erroneous information in the Proposed Rule by making the changes discussed above and publishing those changes in the Federal Register in a new proposed rule, only after the agency has fully evaluated all available data and is in a position to present that data to the public in a manner that interested parties can verify.

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[14] Federal agencies have recognized the obligation to withdraw proposed rules because the underlying data or analyses are insufficient to provide an opportunity for meaningful public input. *See e.g.*, 70 Fed. Reg. 70,166 (Most notably, CMS withdrawing entire practice expense methodology proposed in its Physician Fee Schedule for CY2006 due to incorrect and insufficient data); 69 Fed. Reg. 64,266.

XIII. Conclusion

FAH believes that, however well intentioned CMS' proposed program and payment changes may be, they are to a great degree, as described above, arbitrary, and in many cases, wholly unsupported by data, facts or need. CMS should reject the proposed changes to the SSO payment methodology, should apply the market basket update as developed under the new RPL Market Basket Index, and should revisit other of its proposals in accordance with these comments. At the very least, CMS is required to explain, in far more detail, and in relation to specific and applicable studies, looking at more than one, early LTCH PPS fiscal year's data, why and to what degree such far-reaching changes and massive reductions to reimbursement are indicated. In this context, CMS must also detail in such explanation how and to what extent such changes are likely to impact the quality of patient care, access to care and cost, for not only the LTCH level of care, but also across the general acute care hospital industry and other levels of care, since the types of sweeping changes CMS has proposed will affect not only LTCHs but all providers along a broad continuum of patient care.

* * * * *

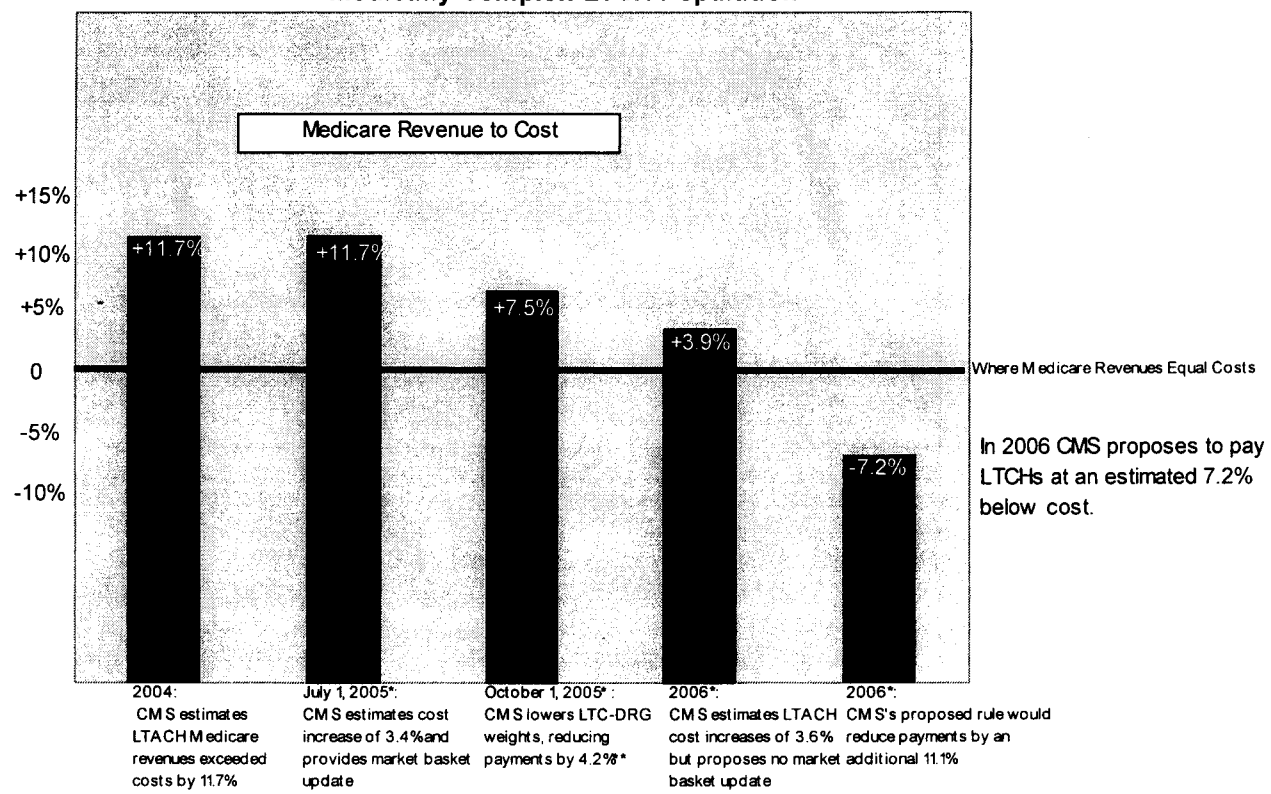
FAH appreciates the opportunity to comment on the LTCH PPS proposed rule. Should you have any questions about our comments or need further information, please contact Steve Speil of my staff at (202)624-1529.

Respectfully Submitted,

Charles N. Kahn III, President
Federation of American Hospitals

EXHIBIT 1

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



*** Estimates; Assumes no changes in volume or intensity of services, which could affect total costs.**

**** Note: CMS rebases LTCH DRG weights annually, with an effective date of Oct. 1 of each rate year. This rebasing is not budget neutral.**

EXHIBIT 2

TABLE 4

Comparison of Short-Term, SSO and All LTCH Patients

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

EXHIBIT 3

TABLE 3

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

EXHIBIT 4

TABLE 2

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

EXHIBIT 5

TABLE 5

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

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

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CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

March 20, 2006

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

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

Dear Dr. McClellan:

In response to the proposed rule concerning the long-term care hospital prospective payment system (LTCH PPS) for rate year (RY) 2007, the California Hospital Association (CHA) respectfully submits comments on behalf of its nearly 500 hospital and health system members. In addition to these comments, CHA supports the comments and recommendations of the American Hospital Association. The proposed rule recommends several significant changes that are of concern to CHA.

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

Since all rehabilitation, psychiatric and long-term care facilities are now paid under a PPS, CMS proposes to implement a rehabilitation, psychiatric and long-term care (RPL) market basket index, a measure of inflation based on 2002 data for the RY 2007 PPS-based portion of payments. CHA generally supports the proposed implementation of the RPL market basket, which is a more targeted and current measure of inflation for the LTCH PPS. We do, however, have some reservations about the new methodology. For instance, CMS had to piece together data from each of the three provider types by using disparate length-of-stay trimming methodologies to create a sufficient data pool. CMS also had to fill in perceived gaps or inadequacies in the data by substituting inpatient PPS data where necessary.

CHA encourages CMS to work with providers to improve the areas of the RPL cost reports where CMS lacks confidence so data from the inpatient PPS is not necessary. We urge CMS to update the RPL market basket on a regular basis, especially since these providers have only recently converted to prospective payment and their cost structures may be changing.

Annual market basket updates are intended to compensate for year-to-year inflationary increases in the cost of delivering health care services. An annual inflationary update to the LTCH PPS, and all prospective payment systems, is essential to maintaining an accurate payment system that helps providers safely care for patients. As such, to exclude a market basket update for LTCHs in RY 2007, as recommended by the proposed rule, is wholly inappropriate. The RY 2007 mar-

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kit basket calculation of 3.6 percent under both the RPL market basket method and the current methodology validates the real inflation costs LTCHs will face next year, which must not be overlooked in the final rule. In addition, to omit the market basket update to offset coding changes is a misuse of the market basket.

Proposed Adjustment for SSO Cases

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

When the LTCH PPS was introduced in 2003, CMS stated in the *Federal Register* that paying for cases treated in excluded hospitals, such as LTCHs, under the inpatient PPS would be "inaccurate and unfair" since these cases were not included in the inpatient PPS system of averages. CMS also noted that paying LTCHs under the inpatient PPS could result in the systematic underpayment of LTCHs. CHA supports these views. As discussed below, we believe the proposed short-stay outlier (SSO) changes would violate the integrity of the LTCH PPS by applying inpatient PPS rates to an LTCH population that is dramatically different from the inpatient PPS population.

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

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

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

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

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

The proposed SSO policy incorrectly 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. Given the current SSO definition, CMS should not expect that the 37 percent rate of SSO cases would continue to drop indefinitely. 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 should be changed.

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

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

A dramatic difference also is found when comparing average length of stay (ALOS). LTCH SSO cases have an ALOS that is more than twice as long as the ALOS for inpatient PPS hospitals, 12.7 days versus 5.6 days, respectively. Analysis by Avalere Health using All Patient Refined DRGs found that for both the total LTCH population and the LTCH SSO population, the presence of the highest levels of medically complex patients (Levels 3 and 4) is approximately double the rate found in general acute hospitals. Similarly high severity levels for both the LTCH population and LTCH SSO cases highlight the inability of referring general acute hospitals and admitting LTCHs to identify SSO cases upon admission to the LTCH. This reality of treating severely ill patients directly challenges CMS' assertion that all SSO cases result from intentionally inappropriate transfers to LTCHs. In addition, these data indicates that patients treated in LTCHs, including SSO cases, are fundamentally different than the patients treated in general acute hospitals.

These analyses of patient severity and cost also validate the need for a separate LTCH payment system with weights and rates based on the distinctly unique population treated by LTCHs. The studies affirm the inappropriateness of applying an inpatient PPS payment, based on the average cost of treating an entirely different set of patients, to LTCHs. The inpatient PPS rates, even when adjusted for outliers, are not designed or intended for the high-complexity, long-stay popu-

lation treated in LTCHs. As such, the agency's proposal to include inpatient PPS rates among the payment alternatives for SSO cases is unjustifiable since it is in direct violation of the Medicare principle of establishing payments based on the average cost of treating specific types of patients. And in this case, the LTCH and general acute populations are distinctly unique from one another.

Recommendations

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

CHA fully supports the June 2004 and March 2006 recommendations by the Medicare Payment Advisory Committee (MedPAC) to develop more specific LTCH criteria that would expand the current facility qualification criterion to target medically complex, long-stay patients. The pending recommendations from the Research Triangle Institute International (RTI) are highly anticipated and should be thoroughly examined by CMS and the LTCH field.

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

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

effective means of ensuring appropriate patients are treated in LTCHs than the agency's SSO proposal and the current policy pertaining to host-hospital referrals to co-located LTCHs.

CHA recommends that CMS authorize and fund expanded QIO review. 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, which would provide assurance to Congress and the Secretary that Medicare funds are being utilized prudently, while preserving the access rights of Medicare beneficiaries.

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

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

Thank you for the opportunity to provide comments on this proposed rule. If you have any questions or would like to discuss our comments, please contact Margot Holloway at (202) 488-4688 or mholloway@calhospital.org, or Janet Carter at (916) 552-7503 or jcarter@calhospital.org.

Sincerely,

Margot Holloway
Vice President, Federal Regulatory Affairs

Janet Carter
Vice President, Continuing Care Services

MH/JC:

Kindred Healthcare

March 20, 2006

BY HAND AND ELECTRONIC FILING

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

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

Dear Dr. McClellan:

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

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

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

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

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

The proposed reimbursement changes that are based upon the data and other information errors in the Proposed Rule will have a direct, adverse impact on the LTCHs operated by Kindred, as well as all LTCHs around the country. Kindred also adopts, in their entirety, the comments submitted on March 10, 2006 by the Acute Long Term Hospital Association ("ALTHA") on behalf of over 300 LTCH locations in the United States. Kindred is an ALTHA member.

I. Proposed Changes to Short-Stay Outlier Payments

A. General Description

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

CMS proposes two specific changes to the SSO payment methodology in the proposed rule. First, CMS would reduce the first part of the current payment formula that is based on costs from 120 percent to 100 percent of the costs of the case. Second, CMS would add a fourth component to the current formula that would allow payment under the LTCH PPS based on an amount comparable to what would be paid to an acute care hospital under the inpatient prospective payment system ("IPPS"). That is, for SSO cases, the LTCH would be paid based upon the lesser of four amounts, one of which would be an amount equivalent to the IPPS payment for the patient stay. Both of these changes would be effective for discharges on or after

July 1, 2006. CMS believes that, under this proposed policy, LTCHs could be paid by Medicare under the LTCH PPS at a rate that is more consistent with the rate paid to acute care hospitals when the LTCHs treat shorter stay patients.

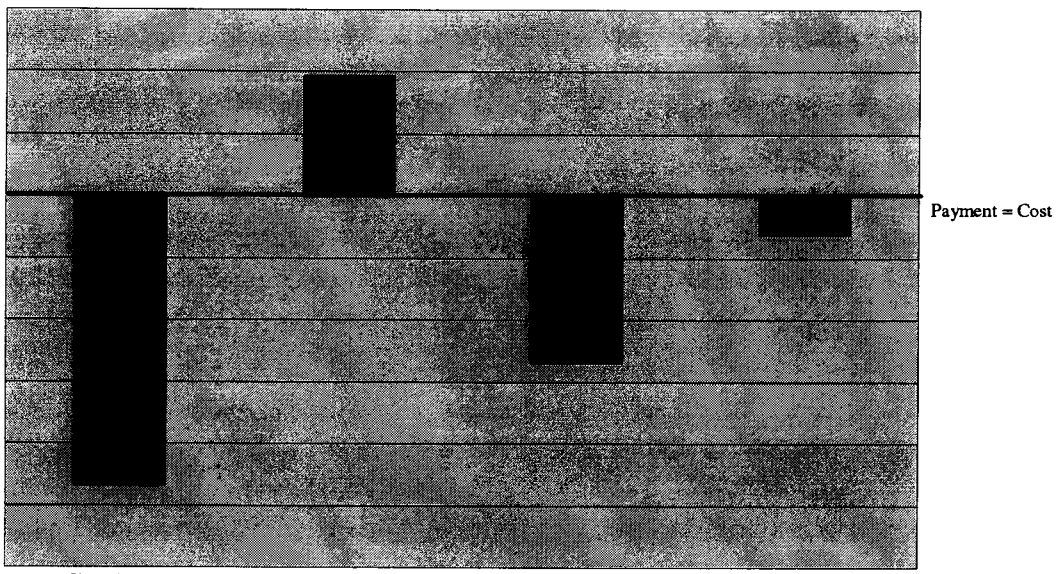
B. Assessment

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

CMS's proposal to limit the payment for SSO cases at the IPPS payment rate would cause LTCHs to be significantly underpaid. For SSO cases, which CMS acknowledges represent fully 37 percent of the patients served by LTCHs, the proposal would cause payment amounts to fall materially below the actual costs of providing care. Payment to LTCHs operated by Kindred for SSO cases under the proposed policy would represent only 53 percent of the actual costs incurred in caring for those patients.

Overall, CMS's proposal would drastically cut payments to Kindred LTCHs by approximately 11 percent, as CMS has calculated. Combined with the proposal to deny the basic inflationary update to cover the rising costs of care, which CMS estimates to be 3.6 percent, and other recent changes to LTCH coding and LTC-DRG weighting, the impact of the proposed revisions to the SSO payment policy will be to pay our LTCHs *significantly* less than it costs them to care for appropriately admitted patients. Kindred has calculated a payment shortfall of minus 6.2% for Kindred's LTCHs, based upon 2005 cost report data (see Figure 1).

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



Source: 2005 Internal Kindred Data
CMS 2006 Proposed Rule

If CMS finalizes these changes to SSO payments, patients with complex medical conditions will lose access to needed hospital care, and general acute care hospitals will incur additional costs since they will be unable to discharge these complex patients to a more appropriate setting. These proposals could impact the ability of Kindred and the entire LTCH industry to provide future ventilator services. This comes at a time when there are public concerns about the ability of hospitals in the United States to provide adequate ventilator services should a pulmonary flu epidemic occur, most notably, a bird flu pandemic. We estimate that 8 to 10 percent of all ventilators in hospitals in the United States are currently located in LTCHs.

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

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

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

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

An example illustrates that CMS's proposed changes to the SSO payment policy bear no relationship to the appropriateness of a patient's admission to an LTCH. Ventilator-dependent patients assigned to LTC-DRG 475 have an average length of stay of 34 days, which results in an SSO threshold of 28 days for these patients. The statutory qualification criteria for LTCHs require that LTCHs have an average length of say of greater than 25 days, which is less that the

SSO threshold for patients assigned to this LTC-DRG. Obviously, therefore, the SSO thresholds do not measure the appropriateness of an admission for LTCH care.

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

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

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

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

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

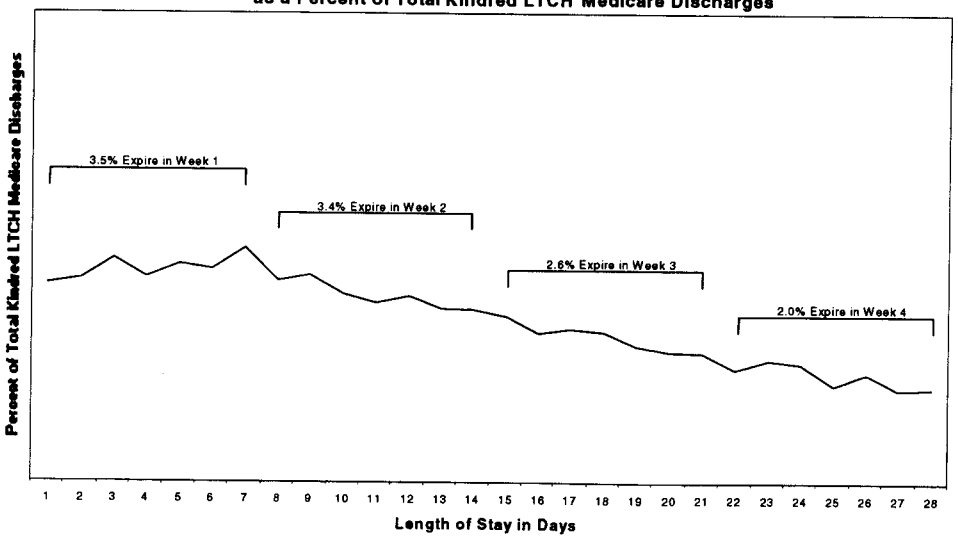
b. CMS's Analysis Is Defective For Not Examining the Types of Short-Stay Outlier Cases, Only a Portion of Which Could Bear Any Meaningful Relationship to CMS's Stated Policy Goals

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

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

The Figure below shows the distribution of LTCH expirations by length of stay for all LTCH discharges (see Figure 2). It shows that 3.5% of Kindred LTCH discharges expire within the first week of admission, another 3.4% expire during week two, 2.6% during week three, and 2.0% expire in week four. Approximately 2.4% of long stay, high cost outlier patients expire. Overall, 18.5% of Kindred LTCH Medicare patients expire. From a clinical perspective, this distribution is not surprising given the medical complexity of LTCH patients and the fact that patient expirations typically occur in the earlier stages of intervention in health care facilities.

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



Note: 18.5% of all LTCH Medicare patients expire
Source: MedPAR 2004

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

In addition, another portion of LTCH SSO patients are characterized as such because their Medicare *coverage* expires during their LTCH stay but before they reach the relevant SSO thresholds. Clearly, loss of Medicare coverage bears no relevance whatsoever to whether the patient was appropriate for admission to an LTCH. For such loss-of-coverage SSOs in particular, there is no relationship between the need for LTCH level care and the length of Medicare stay in the facility, and this patient population should be discounted from statistics used to evaluate current SSO payment policy.

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

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

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

Kindred had 495 cases reviewed by QIOs between 2003 and 2005. Of this total, only 12 cases were denied on the basis of inappropriate admission or medical necessity. That is a denial rate of 2.4%. This data clearly show an immaterial number of LTCH claims denied as the result of QIO reviews. The QIO review data does not support CMS's assumption that SSO cases were inappropriately admitted to LTCHs. On the contrary, QIOs are overwhelmingly finding that LTCH patients have appropriately been admitted and treated in LTCHs.

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

Most important is the clinically documented fact that LTCHs treat a substantially different patient population with virtually no other treatment options – one that is demonstrably

sicker, with higher patient acuity and multiple medical complexities – than the typical short-term general hospital patient in similar diagnostic categories. That is precisely why Congress created this special class of hospitals in 1983. Available Medicare data demonstrate that LTCHs continue to occupy a special niche in post-acute care by serving the most medically complex patients. This data supports modernizing the classification criteria for LTCHs to distinguish and define the unique level of care that LTCHs provide.

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

TABLE 1

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

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

"Short stay" LTCH patients are not less medically complex than the general LTCH patient population. In fact, the diagnoses, medical complexity and severity of illness of "short stay" LTCH patients are generally no different from the general LTCH patient population. For example, the most common "short stay" LTCH patients are ventilator dependent (DRG 475) – the most vulnerable and medically complex patients. Overall for LTCHs, the average length of stay for these patients is about 34 days. However, under CMS' system, even ventilator-dependent patients with a length of stay of 28 days are classified as "short stay" and would be subject to payment penalties. Kindred's data for the five most common SSO LTC-DRGs are

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

presented in Table 2.[2] In Table 2, we provide data from the 2004 MedPAR file which shows the geometric mean length of stay ("LOS") for all LTCH patients, with the SSO threshold stay (or 5/6ths of the geometric mean LOS). The MedPAR file, along with 3M APR DRG Software for the 3M All Patient Refined DRG ("APR-DRG") Classification System, allows us to categorize cases by severity of illness ("SOI"). The APR-DRG severity of illness scores range from 1 to 4, with scores of 3 and 4 considered severely ill. Kindred's data show that SSO cases have similar SOI scores as cases that stay longer, demonstrating the clinical homogeneity of the two groups.

TABLE 2

LTCH DRG	Description	GMLOS for All LTCH Cases	LTCH 5/6 GM: SSO Threshold	Kindred Cases: % in SOI 3,4	Kindred SSO Cases: % in SOI 3,4
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	34.2	28.5	94%	94%
87	PULMONARY EDEMA & RESPIRATORY FAILURE	30.4	25.3	95%	86%
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	20.1	16.8	61%	45%
271	SKIN ULCERS	28.4	23.7	75%	70%
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	21.2	17.7	77%	64%
	All DRG cases (weighted by Kindred case-mix)	27.7		73%	67%

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

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

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

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

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

TABLE 3

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

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

Currently, most LTCHs, including Kindred's LTCHs, use patient assessment tools, such as InterQual® Long-Term Acute Care Criteria (McKesson Health Solutions), to assess the appropriateness of patients' admissions, their continued stays and ultimate discharges from LTCH facilities. Such criteria are among the patient-level standards that MedPAC has recommended be applied by CMS to define more precisely the level of care furnished by LTCHs ("Report to the Congress: New Approaches in Medicare," June 2004) and are used by many of Medicare's QIOs to evaluate the appropriateness of LTCH admissions. LTCH application of the InterQual® Criteria identifies and screens a significant number of patients from admission, thereby ensuring that only those patients who are appropriate for an LTCH stay are admitted. However, these criteria do not identify (and no criteria would be able to identify) whether patients are likely to be SSO patients. The fact that some of the patients ultimately require a shorter LTCH stay than average for their diagnosis and clinical complexity does not change this initial clinical determination of appropriateness.

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

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

changes for SSO cases do not have the ability to change the behavior of admitting physicians. Table 4 below shows the severity of illness ("SOI") and risk of mortality ("ROM") scores (derived from MedPAR 2004 using the APR-DRG grouper software) for Kindred LTCH and short-term general hospital patients.[4] As you can see, there is no indication that LTCHs are admitting less acute patients for a short-stay in order to maximize revenues, as CMS asserts; rather, we find that SSO patients are virtually identical to full-stay patients on several key clinical measures. There are many reasons why patients do not stay the same amount of time in an LTCH, including death or better care outcomes, which do not imply so-called "gaming."

TABLE 4

Comparison of Short-Term, SSO and All LTCH Patients

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

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

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

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

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

> The acute care hospital inpatient prospective payment system is a system of average-based payments that assumes that some patient stays will consume more resources than the typical stay, while others will demand fewer resources. Therefore, an efficiently operated hospital should be able to deliver care to its Medicare patients for an overall cost that is at or below the amount paid under the acute care hospital inpatient prospective payment system. In a report to the Congress, "Hospital Prospective Payment for Medicare (1982)," the Department of Health and Human Services stated that the "467 DRGs were not designed to account for these types of treatment" found in the four classes of excluded hospitals [psychiatric hospitals and units, rehabilitation hospitals and units, LTCHs, and children's hospitals], and noted that "including these hospitals will result in criticism and their application to these hospitals would be inaccurate and unfair."
>
> The Congress excluded these hospitals from the acute care hospital inpatient prospective payment system because they typically treated cases that involved stays that were, on average, longer or more costly than would be predicted by the DRG system. The legislative history of the 1983 Social Security Amendments stated that the "DRG system was developed for short-term acute care general hospitals and as currently constructed does not adequately take into account special circumstances of diagnoses requiring long stays." (Report of the Committee on Ways and Means, U.S. House of Representatives, to Accompany HR 1900, H.R. Rept. No. 98-25, at 141 (1983)). Therefore, these hospitals could be systemically underpaid if the same DRG system were applied to them.

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

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

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

stay.[5] Thus, this proposed policy would create a significant payment cliff for these and other SSO cases with stays close to the SSO threshold.

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

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

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

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

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

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

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

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

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

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

C. Recommendations

Kindred firmly believes that CMS should *not* revise the payment adjustment formula for short-stay outlier ("SSO") patients as proposed. These changes are not supported by the data presented in the proposed rule and herein. Only after CMS has more than one year of cost report data from the transition to LTCH PPS *and* CMS performs a valid analysis of the facility characteristics and resources of LTCHs compared to general short-term care hospitals for the LTCH patient conditions treated can CMS understand whether the current SSO payment methodology is fair. Kindred is confident that CMS *will* find the current SSO payment methodology to be fair because the overwhelming majority of SSO patients are appropriate for LTCH care, based upon clinical admission decisions after applying objective and rigorous clinical screening criteria and comprehensive patient plans of care. The available data supports effective LTCH care, and in certain cases patient mortality during an LTCH stay, rather than inappropriate patient admissions. Moreover, the LTCH PPS, like most prospective payment systems, is based on averages by design – some patients have longer lengths of stay and some shorter. Provided that LTCHs satisfy the statutory requirement of an *average* inpatient length of stay that exceeds 25 days, these hospitals have achieved the desired balance of short- and long-stay patients envisioned by LTCH PPS. We also have concerns about the ability of the fiscal intermediaries to implement the necessary system edits for these SSO payment changes by the July 1, 2006 effective date. CMS needs to take this into account so that LTCHs continue to be paid in a timely manner.

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

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

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

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

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

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

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

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

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

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

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

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

policy, even if given more time. A phase-in will not cure these fundamental shortcomings with CMS's proposed approach.

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

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

It is noteworthy that, in the March 2002 Proposed Rule, CMS originally proposed to pay SSOs at 150% of cost to account for the fact that very short stay cases would be getting a per diem amount at a much lower level. CMS then determined that higher SSO payments were required to produce an LTCH payment system that was, overall, adequate and met the statutory mandate to "maintain budget neutrality." Under any approach that CMS chooses, and any percentage of cost that CMS pays short stay cases, it is vitally important that CMS evaluate the overall adequacy of the LTCH payment system as a whole, with due consideration of how those decisions affect the ability of LTCHs to meet patient care needs.

II. Proposal to Not Update the RY 2007 Federal Rate

A. General Description

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

B. Assessment

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

The case-mix index ("CMI") is defined as an LTCH's case weighted average LTC-DRG relative weight for all its discharges in a given period. CMS characterizes a change in CMI as either "real" or "apparent." A "real" CMI increase is an increase in the average LTC-DRG relative weights resulting from the hospital's treatment of more resource intensive patients. An "apparent" CMI increase is an increase in CMI due to changes in coding practices, according to CMS. CMS believes that freezing the federal rate for RY 2007 will eliminate the effect of

coding or classification changes that do not reflect changes in LTCHs' case-mix (i.e., the federal rate will reflect only "real" CMI and not "apparent" CMI). CMS reaches this conclusion by looking at a data analysis performed by 3M. The 3M analysis compared FY 2003 LTCH claims data from the first year of implementation of LTCH PPS with the FY 2001 claims data generated prior to the implementation of LTCH PPS (the same LTCH claims data CMS used to develop LTCH PPS). 3M found that the average CMI increase from FY 2001 to FY 2003 was 2.75 percent. CMS then assumes that the observed 2.75 percent change in case-mix in the years prior to the implementation of LTCH PPS represents the value for the "real" CMI increase. CMS then makes a second assumption that the same 2.75 percent "real" CMI increase remained absolutely constant during the LTCH PPS transition period. Because the 3M data showed a 6.75 rise in CMI between FY 2003 and FY 2004, CMS concludes that 4.0 percent of that increase represents the "apparent" CMI increase due to improvements in LTCH documentation and coding.

The first error with the assumptions that CMS makes here is that there are a number of LTCHs that did not begin the transition to LTCH PPS until close to the start of FY 2004 – the second year of the LTCH PPS transition period. Significantly, all of Kindred's 44 LTCH hospitals (out of a total 280 LTCHs operating in FY 2003) did not receive *any* portion of the LTCH PPS federal rate until September 1, 2003 – one month shy of the FY 2004 rate year. The evidence available to Kindred suggests that there were other LTCHs that went onto LTCH PPS late in the FY 2003 rate year as well. So CMS's assumptions that 4.0 percent of the 6.75 rise in CMI between FY 2003 and FY 2004 can be attributed to better LTCH coding and documentation is simply false – at least with respect to Kindred's LTCHs. Therefore, the proposed elimination of the update to the federal rate for RY 2007 is based on at least two false assumptions and a failure to use the proper data (in this case, the case-mix data from FY 2004, when all LTCHs in operation at the time LTCH PPS went into effect had begun the transition to LTCH PPS). Moreover, to prove CMS's assumptions, it would need to compare the CMI increases for LTCHs that elected reimbursement at the full federal rate at the beginning or at some time during the transition period against the CMI increases for LTCHs that chose to go through the full five-year transition period to the federal rate. In addition, during the first year of the transition period, the federal rate only made up 20 percent of the LTCH's payment for those LTCHs that chose to transition to LTCH PPS. This relatively small portion of the overall payment makes it far less likely that LTCHs were aggressively coding LTCH stays during FY 2003 in a manner that would account for the *entire* differential between the pre-LTCH PPS average CMI increase and the post-LTCH PPS average CMI increase. In sum, CMS makes a number of false assumptions to explain a rise in CMI for LTCHs during the transition period to LTCH PPS, without considering other factors or data elements that suggest real CMI increases, due to real changes in LTCH treatment of more resource intensive patients, rather than deliberate coding efforts to enhance payments. On this basis alone, the LTCH PPS federal rate for RY 2007 should be updated.

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

The second source of erroneous data that CMS used to propose a rate freeze for RY 2007 is a review by a Medicare program safeguard contractor working with a fiscal intermediary that examined a sample of LTCH claims with specific diagnoses in one LTCH and determined that the majority of those patients were not "hospital-level" patients, but were more suitably skilled nursing facility ("SNF") patients. CMS states that a Medicare QIO reviewed a sample of the claims that had been determined not to be hospital-level patients by the Medicare program safeguard contractor and concurred with its assessment of most of those cases. CMS adds that they have other anecdotal information about investigations of LTCHs treating patients that do not require hospital-level care. CMS concludes that these findings add further support for its assumptions that the increase in LTCHs' CMI is primarily due to factors other than "real" CMI.

On its face, this is the worst kind of data for CMS to use when making an important policy decision such as a payment rate change. The conclusions reached by a Medicare program safeguard contractor after a *single* review using only a *sample* of claims from a *single* LTCH, where some of the contractor's conclusions were later disputed by a QIO, bears no meaningful relationship to the patients treated by the other 374 LTCHs that are currently paid under LTCH PPS. The same can be said for the anecdotal information about similar LTCH reviews that CMS mentions. CMS fails to show a relationship between one LTCH's behavior with regard to admitting what are disputably a few inappropriate cases and the case mix of any other hospitals or industry-wide case mix increases. CMS assumes that one LTCH's behavior is similar across all LTCHs without presenting data to show that this is in fact true. CMS did not analyze the individual cases of other LTCHs to determine if the one case it reviewed was more widespread.

3. The CMS Analysis of LTCH Margins Is Flawed

The third source of erroneous data CMS discusses in the proposed rule as support for the rate freeze is an internal CMS analysis that basically retraces the steps MedPAC took to examine LTCH margins before and after implementation of LTCH PPS. CMS says full-year cost report data from FY 2003 indicates that LTCH Medicare margins were 8.8 percent in that year, and preliminary cost report data for FY 2004 indicates LTCH Medicare margins of 11.7 percent for that year. CMS says that LTCH Medicare margins prior to LTCH PPS (going back to 1996) ranged from -2.2 percent in FY 2002 to 2.9 percent in FY 1997. However, upon a closer examination of the MedPAC data on LTCH margins, the data shows that almost a quarter of LTCHs (23% to be precise) had *negative* Medicare margins in 2004. In addition, MedPAC did not take into consideration the effect of the 25 percent rule on reimbursement to LTCH hospitals-within-hospitals for admissions from the host hospital when modeling LTCH Medicare margins. See MedPAC Meeting Transcript, pg. 164. Thus, it is clear that CMS has not properly interpreted the data and has drawn incorrect conclusions from the selected observations about LTCHs' Medicare margins to support its proposed freeze of the LTCH PPS federal rate in RY 2007.

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

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

The discussion in the proposed rule regarding changes in CMI since the implementation of the LTCH PPS fails to address other recent changes that have had a material affect on LTCH coding and payment. Namely, CMS has already corrected any coding issues from 2004 by reweighting the LTC-DRG weights earlier this year. In fact, each year of the LTCH PPS, CMS has reweighted the LTC-DRGs in a non-budget neutral manner to realign LTCH payments

with costs, and reserves the right to do so going forward. In the IPPS Final Rule for FY 2006, published August 1, 2005, CMS reduced the LTC-DRG weights (resulting in an agency-estimated 4.2% reduction in payments to LTCHs) for the exact same reason that CMS is now proposing no market basket update for RY2007 – because PPS reimbursements to LTCHs were higher than LTCH costs in 2004.

Through the CMI analysis in this proposed rule, CMS has basically documented the same purported phenomenon that it found a few months ago and documented in the IPPS final rule – that during the transition to the PPS, LTCH coding practices are resulting in patients being assigned to DRGs with reimbursements that are higher than the LTCH's costs for those patients. As stated above, CMS sought to eliminate any differences between reimbursements and costs in 2004 by reducing LTC-DRG weights in 2006 (and it did the same for 2003 differences in the 2005 LTC-DRG weights). Because the same alleged PPS coding transition problem was previously corrected in the 2006 IPPS rule, there is no need to eliminate the market basket update in RY 2007. Eliminating the update for RY 2007 would be nothing more than an unjustified penalty upon LTCHs.

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

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

C. Recommendations

CMS should allow a full update to the LTCH PPS federal rate for RY 2007. Projected or assumed "overpayments" in the LTCH system are effectively eliminated from the payment system on an annual basis as CMS recalibrates the LTC-DRG weights or makes similar adjustments to other aspects of the LTCH PPS. CMS has achieved payment adequacy through the DRG reweighting. A zero market basket update would be a duplicative and unnecessary cut in LTCH payments to address the very same issue that CMS just addressed in the IPPS Final Rule for FY 2006. CMS also needs to account for other changes in LTCH coding, including the amended guidelines regarding classification of patients under DRG 475, when proposing changes to the update.

III. Monitoring/RTI International Study

A. General Description

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

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

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

B. Assessment

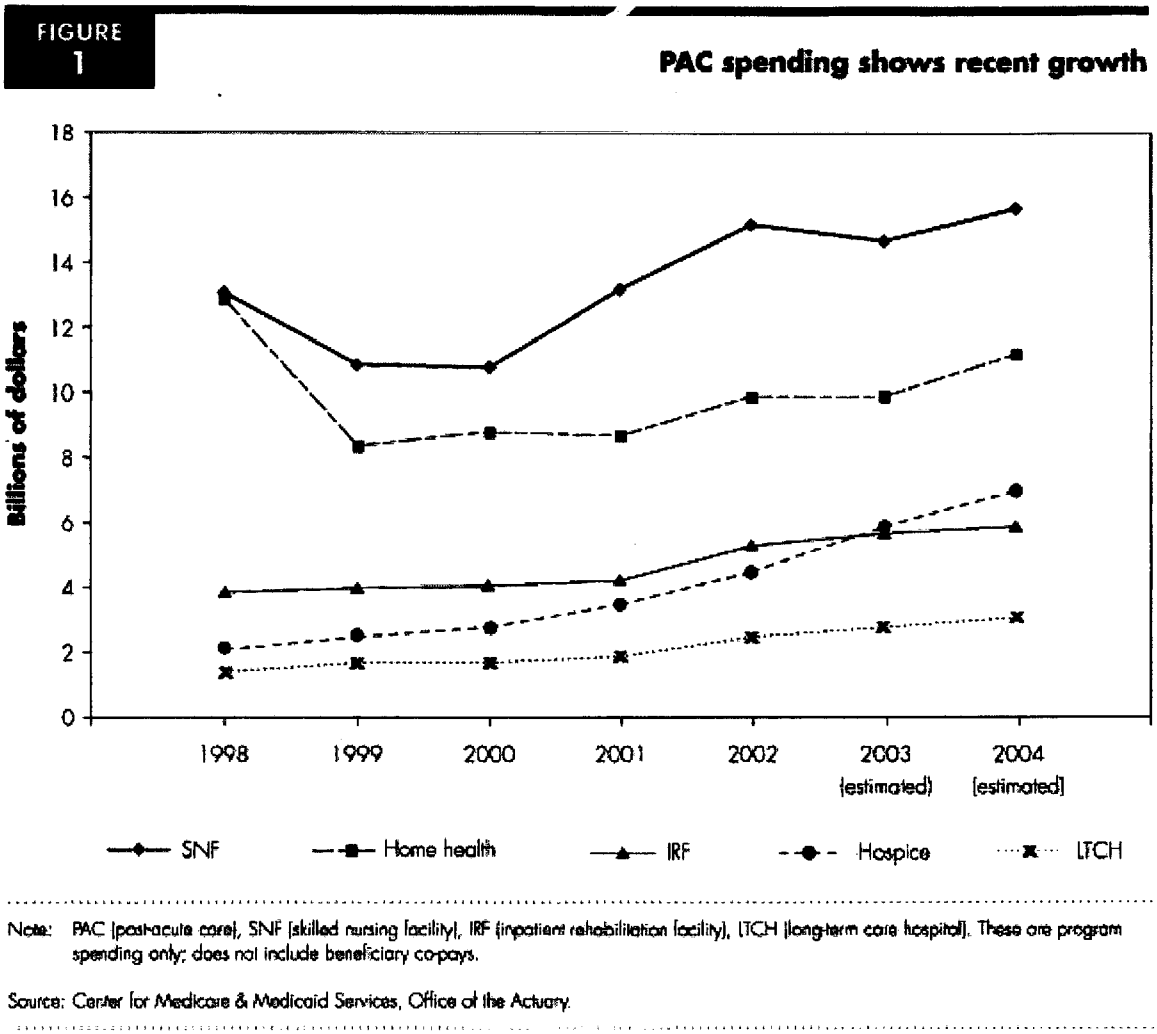
1. Insufficient Description of Methodology to Comment

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

2. Causes of Industry Growth

CMS states that a goal of the "research is to determine whether this [increase in numbers] is due to growing patient demand or industry response to generous payment policies." However, no data are presented that indicate that RTI has studied this issue. Therefore, it is not possible for the industry to submit meaningful comments until such time as CMS publishes these results. The assertion that LTCHs have "increased in numbers exponentially" is not mathematically correct, nor is it meaningful without context. In MedPAC's June 16, 2005 prepared testimony before Congress on Medicare post-acute care, MedPAC presented the following figure to illustrate Medicare spending growth for various post-acute care provider types between 1998 and 2004 (see Figure 3 (taken from Figure 1 at page 3 of MedPAC testimony)). The data show that overall Medicare spending on LTCHs remains far less than all other post-acute care provider types, and growth in spending on LTCHs has not outpaced other types of post-acute providers during this period.

FIGURE 3



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

[6] In the proposed rule, CMS estimates RY 2007 spending for LTCHs to be $5.27 billion (see 71 Fed. Reg. at 4,681). This figure excludes an SSO policy effect of 11.1% and includes a market basket update of 3.6%. By reducing the $5.27 billion by the CMS-estimated 11.1% SSO policy effect, and by eliminating the market basket update, spending under existing policies would be $4.5 billion in 2007. CBO estimates of net mandatory Medicare spending in RY 2007 is $383.4 billion, meaning that LTCH spending projections equal 1.2% of net mandatory Medicare spending. If you assume, as does CMS, that the 11.1% estimated reduction for the proposed changes to SSO payments does not occur, LTCH spending is projected to be just 1.3% of net mandatory Medicare spending in 2007.

3. Patient Outcomes

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

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

4. Descriptions of LTCH Patients

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

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

Kindred, in collaboration with ALTHA and other LTCH providers, conducted an evaluative study of the LTCH provider community with a focus on patient and facility level characteristics. This study builds on previous work we have done to identify appropriate LTCH certification criteria. The all patient refined-diagnosis related groups ("APR-DRGs") system permits users to classify hospital patients not only by resource utilization, but also in terms of patient SOI and likelihood of mortality.[7] The Figure below shows that the vast majority of

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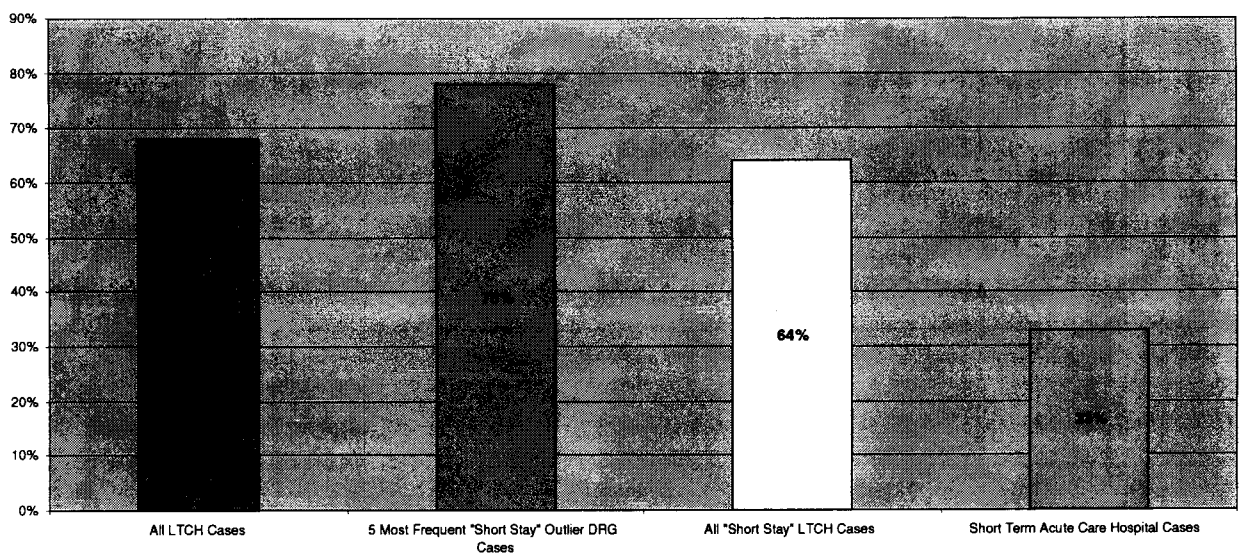
[7] APR-DRG scores are expressed as categories 1 to 4 and are organized to capture the risk of mortality for each patient using age, primary diagnosis, co-morbidities, and certain medical

LTCH patients are classified in the highest APR-DRG SOI categories – whether one looks at all LTCH cases, just the five most frequent "short stay" outlier DRG cases, or all "short stay" LTCH cases – but that only a third of short term care hospital patients are classified in the highest SOI categories (see Figure 4). This supports the conclusion that LTCH patients are, in fact, much sicker than short term hospital patients.

FIGURE 4: LTCH Patients are Much Sicker than Average Short Term Hospital Patients

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



***Source: MedPAR 2004**

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

The next Figure compares patients in LTCHs and short term care hospitals using the APR-DRG "risk of mortality" categories (see Figure 5). It shows that approximately half of all LTCH cases and half of all "short stay" LTCH cases are classified in the highest APR-DRG "risk of mortality" categories, yet only about a quarter of all short term care hospital cases are classified in this manner. Therefore, LTCH patients are much more likely to expire during their hospital stay than short term care hospital patients.

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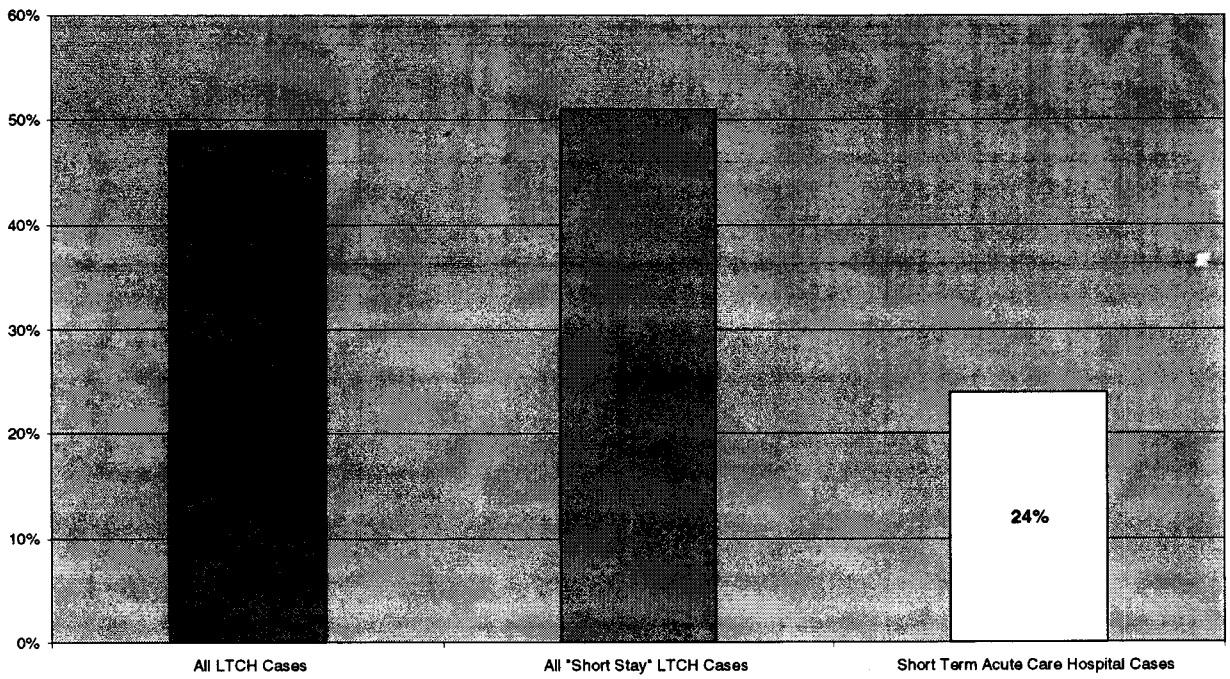
procedures. The SOI categories are rated from 1 to 4 as minor, moderate, major, and extreme, respectively. Both the acute care hospital MedPAR data and LTCH data were run through the APR-DRG GROUPER to determine SOI scores associated with ach case.

Figure 5: LTCH Patients Have a Higher "Risk of Mortality" than Average Short Term Hospital Patients

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



***Source: MedPAR 2004**

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

Additionally, the acute care hospital MedPAR file shows that cases discharged to LTCHs frequently have a higher SOI than other acute patients discharged to SNFs or IRFs. Sixty-nine percent of patients discharged to LTCHs have a major or extreme risk of mortality during their acute hospital stay compared to less than half of SNF patients and only 36 percent of IRF patients. Table 5 shows the percent SOI distribution for LTCH, SNF, and IRF cases.[8]

TABLE 5

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

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

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

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

C. Recommendations

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

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

A. General Description

In the proposed rule, CMS states a continued concern over "inappropriate patient shifting" between acute care hospitals and LTCHs, even following implementation of the hospital within hospital ("HIH") 25% rule at 42 C.F.R. § 412.534. Based on the agency's continued monitoring efforts, CMS believes that LTCH co-location with a short-term acute care hospital is not a prerequisite for a short-term acute care hospital to discharge a patient to an LTCH prematurely. CMS states that many freestanding LTCHs accept the majority of their patients from one acute care hospital independent of co-location. Additionally, CMS believes the HIH 25% rule is intentionally being circumvented by "creative patient shifting" in communities where there are multiple HIH and freestanding LTCHs. CMS states that it has been brought to their attention that some acute care host hospitals have arranged to cross-refer patients to HIH or satellite LTCHs of other acute care host hospitals within the same community. Another situation CMS discussed is when a patient is admitted to an LTCH HIH from the host hospital where the patient was provided initial treatment and then transferred to a freestanding location of that same LTCH. CMS states that the growth in the LTCH industry is now occurring through the development of freestanding LTCHs, and that even those hospitals may be in danger of functioning as units of a primary referral source. CMS believes that the intent of the HIH 25% rule "to hinder the *de facto* establishment of an LTCH unit of a host hospital, which is precluded by law," is being circumvented by these activities. 71 Fed. Reg. at 4,697. CMS says that it is considering appropriate adjustments to address this issue.

B. Assessment

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

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

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

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

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

In this proposed rule, CMS cites three data sources for its statements about alleged improper patient shifting involving freestanding LTCHs. The first is a Lewin Group study that CMS states was commissioned by an LTCH trade association. CMS does not state that it reviewed the study or the underlying data – only that CMS was informed by the association of certain findings from the study. In fact, the Lewin Group study was commissioned by the National Association of Long Term Hospitals ("NALTH"). In NALTH's comments to CMS about this proposed rule, they take issue with the conclusions that CMS reached from this study for failing to recognize the demographics of referrals to post-acute providers throughout the United States. See NALTH Comments, dated March 13, 2006, pgs. 24-25. NALTH requested that CMS correct the public record with regard to this study and fully report the Lewin Group's conclusions.

The second source of data CMS refers to is anecdotal information about "frequent 'arrangements' in many communities between Medicare acute and post-acute hospital level providers" that do not have common ownership or governance, but are allegedly engaged in patient shifting due to "mutual financial advantage." 71 Fed. Reg. at 4,697. This information is vague, at best. CMS provides no other information about this anecdotal information, and no way for interested parties to confirm the validity of this data.

The third source of data here is a data analysis that CMS states it conducted of sole-source relationships between acute care hospitals and non-co-located LTCHs. CMS presents certain data points from the FY 2004 and FY 2005 MedPAR files: 63.7 percent of 201 freestanding LTCHs have at least 25 percent of their Medicare discharges admitted from a sole acute care hospital; for 23.9 percent of freestanding LTCHs, CMS says the number of referrals is 50 percent or more; and 6.5 percent of freestanding LTCHs obtain 75 percent or more of their referrals from a single hospital source. CMS, however, fails to present any data whatsoever concerning other types of acute or post-acute care hospitals and the proportion of patients which they admit from a single referral source. Without this data as a basis of comparison, it is impossible to know whether the percentages CMS cites from its analysis are unusual in the hospital sector.

Thus, it is clear that CMS is not in a position to make further policy changes pertaining to freestanding LTCHs without a more thorough and meaningful analysis of available data. In this regard, we continue to believe that the HIH 25% rule is an ineffective method of addressing this policy issue. We believe this rule does nothing to distinguish LTCH HIHs who are following the letter and spirit of the separateness and control regulations from those who are not. CMS should focus its resources on enforcing its existing requirements for HIHs at 42 C.F.R. § 412.22(e), rather than take the premature step of expanding this payment penalty to freestanding hospitals. Until the transition period for the HIH 25% rule is completed for all LTCH HIHs (between October 1, 2007 and September 30, 2008), CMS cannot know whether this payment adjustment is achieving the stated policy goal without having undesirable effects on patient care.

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

CMS notes that the growth in new Medicare hospitals from 2003 to the start of 2005 increased from 200 to 378. However, utilizing the Provider of Service public use file provided

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

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

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

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

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

C. Recommendations

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

Kindred recommends that CMS focus on enforcing its existing regulations at 42 C.F.R. § 412.22(e)(5)(i-iii) for maintaining HIH separateness from other hospitals. In addition, if CMS is concerned about "patient shifting," or the conversion of HIHs to freestanding LTCHs, it is well within the agency's regulatory authority to address those issues through the provider enrollment process (*e.g.*, by refusing to permit the transfer of provider numbers to new freestanding LTCHs engaging in inappropriate activities). It is neither necessary nor appropriate to apply penalties to all freestanding LTCHs that have operated in compliance with applicable regulations. We also recommend that CMS work with the LTCH industry to develop new certification criteria that more directly targets the entire LTCH provider category and permit certification for only those LTCHs that provide care to medically complex cases with multiple co-morbidities. These criteria should reflect MedPAC's recommendations and focus on patient characteristics, the structure and operation of LTCHs, and ensuring medical necessity. Input from the provider community should be used in developing any such criteria. In addition, such new criteria should be subject to notice and comment through rule-making procedures because MedPAC's recommendations are general and the provider community must weigh any specific CMS proposals.

V. Postponement of One-Time Budget Neutrality Adjustment

A. General Description

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

B. Assessment

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

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

CMS asserts in the proposed LTCH PPS rule for RY 2007 that it presently lacks sufficient data with respect to FY 2003 such that it can reasonably decide whether to impose the one-time rate adjustment. Nonetheless, CMS also states that its "most complete full year of LTCH cost report data are from FY 2003" – the very year in which the original budget neutrality

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

Consequently, Kindred submits that postponing the deadline for the one-time prospective adjustment would be arbitrary and capricious. The postponement of the deadline would allow CMS to wait until "any significant difference" arises in the aggregate to trigger the one-time adjustment, regardless of whether the cost data for FY 2003 actually justifies such an adjustment or not. However, the regulation clearly expresses that the one-time adjustment option is designed to correct "any significant difference" between actual payments and estimated payments for the first year of the LTCH PPS, not for an ongoing and indeterminate number of years.

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

C. Recommendations

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

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

A. General Description

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

B. Assessment

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

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

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

C. Recommendations

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

VII. High-Cost Outlier Regression Analysis

A. General Description

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

B. Assessment

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

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

C. Recommendations

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

VIII. SSO Fixed Loss Threshold

A. General Description

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

B. Assessment

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

C. Recommendations

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

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

A. General Description

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

B. Assessment

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

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

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

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

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

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

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

C. Recommendation

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

X. CMS Failed to Accurately Complete the Regulatory Impact Statement

A. General Description

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

B. Assessment

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

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

undergone extended stays at acute care hospitals, making it even more difficult to predict how long they will stay. While the 11.1 percent decrease in LTCH payments alone would very likely affect patient care, CMS's implied recommendation that LTCHs predict in advance each patient's length of stay, if actually followed by LTCHs, would undoubtedly result in an adverse impact on quality of care and access to services for this fragile population of Medicare beneficiaries.

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

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

C. Recommendations

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

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

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

Kindred seeks the correction of erroneous information disseminated by CMS concerning the costs and patient characteristics of LTCHs. The erroneous information violates the Federal

Data Quality Act (the "DQA"),[9] the implementing guidelines issued by the Office of Management and Budget ("OMB Guidelines"),[10] HHS ("HHS Guidelines"),[11] and CMS ("CMS Guidelines").[12] Per Section 515 of the DQA, Kindred seeks the revision of erroneous data relied upon and disseminated by the Secretary (the "Secretary") of HHS and the Administrator (the "Administrator") of CMS in the formulation and publication of the Long-Term Care Hospital Prospective Payment System ("LTCH PPS") payment rates and policies for RY 2007 (July 1, 2006 through June 30, 2007).

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

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

On September 30, 2002, HHS announced that its guidelines implementing the OMB Guidelines would be available on the Internet at www.hhs.gov/infoquality. See supra, fn 3. As directed by the HHS Guidelines, CMS issued agency-specific guidelines. See supra, fn 4. Information subject to the CMS Guidelines includes the following:

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

(2) Statistical or actuarial information;

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

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

More specifically, the program information subject to the CMS Guidelines includes program information, statistical data sets, research and evaluation reports, technical reports, and

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

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

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

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

payment updates. A number of these types of program information were used by CMS in developing the proposed rule.

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

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

A. Utility Standard

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

B. Objectivity Standard

In defining "objectivity," the CMS Guidelines specify that "[o]bjectivity involves a focus on ensuring that information products are presented in an accurate, clear, complete, and unbiased manner." Id. § V(B). "Objectivity is achieved by using reliable data sources and sound analytical techniques, and carefully reviewing information products prepared by qualified people using proven methods." Id. Each of the data issues and erroneous assumptions discussed above show that CMS has failed to maintain objectivity in developing the proposed rule. CMS has

repeatedly performed cursory analyses of limited data sets to reach biased assumptions. CMS has failed to consider key data that is readily available to the agency. CMS also cites a single review by a Medicare program safeguard contractor and other anecdotal information about LTCH reviews. These are not reliable data sources, as the CMS Guidelines require. In sum, CMS has not met the objectivity standard in the CMS Guidelines. CMS needs to satisfy this objectivity standard before finalizing its LTCH payment proposals.

C. Integrity Standard

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

D. Transparency and Reproducibility Standard

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

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

A. The APA Requires Rulemaking With Meaningful Comments

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

Pursuant to the Administrative Procedures Act (the "APA"), federal agencies must "give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments." 5 U.S.C. 553(c). Courts have consistently held that the public's right to participate in the rulemaking process requires an agency to "provide sufficient factual

detail and rationale for the rule to permit interested parties to comment meaningfully." Florida Power & Light Co. v. United States, 846 F.2d 765, 771 (D.C. Cir. 1988). See also Home Box Office, Inc. v. FCC, 567 F.2d 9, 35 (D.C. Cir. 1977); United States v. Nova Scotia Food Products Corp., 568 F.2d 240, 251-52 (2d Cir. 1977).

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

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

Like Portland Cement, CMS's reliance on inadequate data and the resulting absence of reasoned scrutiny provides no opportunity for the public to offer meaningful support or criticism of the proposed LTCH rule. It is also questionable whether CMS adequately reviewed the methodology employed by 3M and MedPAC before adopting their research in the proposed rule. See City of New Orleans, 969 F.2d at 1167. Consequently, CMS should withdraw the proposed rule until such time that the agency can obtain more inclusive LTCH data and provide a reasonable analysis thereof.[13]

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

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

written response to its FOIA request, in violation of the agency's own regulations. The request has been assigned a case number (C06FOI0920), but the case officer has made no effort to provide the request or a list of the requested records to anyone outside of the CMS FOI Group. These failings have thwarted our efforts to test the limited data and other information that CMS believes support its proposals.

B. Correction of Erroneous Information

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

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

C. Public Notice of Correction

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

XIII. Conclusion

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

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

Sincerely,

William Altman
Senior Vice President, Kindred Healthcare

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CHA

COLORADO HEALTH & HOSPITAL ASSOCIATION

MAR 2 2006

March 17, 2006

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

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

Dear Administrator McClellan:

The Colorado Health and Hospital Association is writing to express serious concern about the proposed rule to reduce Medicare reimbursement to long-term acute care hospitals.

First, if implemented, the proposed rule will have a serious impact on access to critical care and may place long-term acute care hospitals' existence in jeopardy. As you know, long-term care hospitals provide acute care to patients who are demonstrably sicker, have higher acuities, and have more co-morbidities than patients in short-term acute care hospitals. Grouping long term care hospitals with general hospitals for payment purposes is inappropriate. Long-term acute care hospital patients have different requirements than patients in general hospitals; the payment methodology for these hospitals should reflect those differences.

Second the proposed rule is contrary to the concept of prospective payment systems. CMS is eliminating any chance for long-term acute care hospitals to overcome the losses of caring for patients whose costs of treatment exceed reimbursement levels. In essence, CMS is punishing long-term acute care hospitals for treating Medicare patients with varying costs and length of stay.

Finally, the impact does not stop with long-term acute care hospitals. Physicians transfer patients who need acute long term care from general acute care hospitals. If transfers cannot be made, all hospitals will be affected. Most importantly, the proposed rule may preclude patients from receiving the appropriate level and type of care.

CHA encourages CMS to await the results of the study it commissioned regarding payments to long- term acute care hospitals that is currently underway before implementing any changes to the payment methodology. Thank you for your attention to this matter.

Sincerely,

Peter D Freytag
President and CEO (Interim)

CHA is a not-for-profit association of hospitals and health systems, committed to improving the health status of all Coloradans residents. Founded in 1921, it represents 82 hospitals in 60 communities throughout Colorado, provides education for healthcare leaders and is the source of information about health care issues and trends.

Neil has been home
five weeks and continues
to breathe on his own.
We are so grateful to
Life Care for bringing him
to this point after three
years of ventilator dependence.
Thanks to nursing, therapy,
housekeeping, speech, and
everyone who was so nice to
us. We continue to
work toward total recovery.

Knowing people
nice as you
Gives life
a brighter touch,
And so to each
and all of you—
Thanks very, very much!

Neil, [illegible] & [illegible]

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MAR 2 0 2006

NEW ENGLAND SINAI HOSPITAL AND REHABILITATION CENTER
150 YORK STREET
STOUGHTON, MA 02072
781-297-1201

March 15, 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:

As a member of the New England Sinai Hospital Board of Directors, I would like to submit the following comments on the proposed rules published on January 27, 2006 at 71 Fed. Reg. 4648 *et seq.* This rulemaking seeks significant changes to the admission practices of long-term care hospitals (LTCHs) as well as changes in payment policies.

The New England Sinai Hospital has carried forth a tradition in service to the poor of Boston and southeastern Massachusetts since it's founding in 1927 as the Jewish Tuberculosis Sanatorium in Rutland. Throughout the hospital's rich history, it has continued to provide healthcare services to this population. Today, operating as a 212-bed hospital in Stoughton, Sinai provides pulmonary care, ventilator care, complex medical care and physical rehabilitation as well as a full array of outpatient services.

A large percentage of Sinai's patients are public payor dependent, with about 70% being Medicare and 15% being Medicaid. CMS' proposed short-stay outlier rule and zero update proposal, would drastically reduce payments to New England Sinai Hospital in fiscal year 2007 by approximately 17 percent, forcing New England Sinai Hospital to operate at a loss when treating Medicare patients. The CMS proposed rule would result in a $5.4M operating loss from Medicare, which cannot be recovered from other payors because of their small numbers.

For almost 80 years, New England Sinai has had an exemplary record in providing care to long-term acute care patients. Over these nearly eight decades Sinai has continually and constantly demonstrated its commitment to this patient population, and it is dedicated to continuing this commitment well into the future. However, the continued operation of New England Sinai Hospital and the patients it serves will be placed in jeopardy if CMS adopts the proposed short-stay outlier rule and zero update proposal. New England Sinai Hospital, with its long-standing history of caring for these patients, and older hospitals like Sinai, should at the very least be grandfathered from implementation of this rule. This would insure that the good work that has been done by these hospitals is not threatened due to the perceived abuses of other newer hospitals. As a Board member of New England Sinai Hospital, I urge CMS to not adopt the proposed short-stay outlier rule and zero update proposal.

Short-Stay Outlier Proposal

CMS states the objective of the Short-Stay Outlier (SSO) rule is to preclude admission of SSO patients to LTCHs. CMS' presumption is that SSO cases should have remained in acute hospitals. 71 Fed. Reg. at 4648. The following discussion explains why this presumption is incorrect.

1. Through the SSO policy CMS has assumed that SSO patients in LTCHs are similar to short-term acute hospital patients assigned to the same DRGs. To the contrary SSO patients have a relative case-mix index of 2.0592 which is 110% greater than the relative case-mix index of 0.98734 assigned to patients with the same DRGs in short-term acute hospitals. Therefore, these SSO patients have a higher medical acuity and use more medical resources than are reflected in short-term hospital payments.

The higher acuity of LTCH SSO cases is further demonstrated by a higher death rate of 19.61% for SSO cases in LTCHs vs. 4.81%. The average length of stay of SSO cases in LTCHs is 72% greater (12.7 days vs. 7.4 days) than the average stay in short-term acute care hospitals.[1]

2. CMS also assumes that LTCHs are able to predict, prior to admission, which patients will become SSOs. There is no way for LTCHs to make such a prediction. Long-term care hospital patients suffer from multi-system body failures with peaks and valleys in their medical conditions. Their conditions may unpredictably improve or deteriorate at any time. SSO cases are admitted to LTCHs at the appropriate level of care based on the medical judgment of their treating physicians. It is impossible to pre-screen patients and effectively identify which patients may become SSOs. There are a myriad of reasons why a patient admitted to an LTCH may become a SSO:

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

- Some SSO cases may achieve medical stability sooner than originally expected;
- Some cases may become SSO and require discharge to an acute hospital due to a deteriorating condition or a new condition which develops subsequent to their admission to an LTCH;
- Some patients admitted to LTCHs from acute care hospitals may become SSO cases due to 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;
- Some patients may sign themselves out against medical advice.

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

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

5. 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.

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

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

No Fiscal Year 2007 Update

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

In view of the foregoing, I respectfully request CMS to not adopt the proposed SSO policy and to grant LTCHs a reasonable inflation update for fiscal year 2007. We would also like CMS to consider grandfathering those institutions with a history of providing this level of care.

Sincerely,

Dolores Fine RN

Member, New England Sinai Board of Directors

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Kettering Medical Center
Sycamore

Kettering Medical Center Network

MAR 2 0 2006

March 16, 2006

NETWORK FACILITIES

Charles F. Kettering Memorial Hospital
3535 Southern Boulevard
Kettering, Ohio 45429
(937) 298-4331

Kettering Medical Center Sycamore
2150 Leiter Road
Miamisburg, Ohio 45342
(937) 866-0551

Grandview Hospital
405 W. Grand Avenue
Dayton, Ohio 45405
(937) 226-3200

Southview Hospital
1997 Miamisburg-Centerville Road
Centerville, Ohio 45459
(937) 439-6000

Kettering Hospital Youth Services
5350 Lamme Road
Dayton, Ohio 45459
(937) 534-4600

Kettering College of Medical Arts
3737 Southern Boulevard
Kettering, Ohio 54529
(937) 395-8601

Sycamore Glen Retirement Community
317 Sycamore Glen Drive
Miamisburg, Ohio 45342
(937) 866-2984

KETTERING SERVICES & FACILITIES

Alliance Cancer Center
Conover Health Plus
Dayton Eye Surgery
Englewood Health Center
Franklin Physicial Therapy & Fitness Center
Hyperbaric Medicine Center
Indian Ripple Family Health Center
Kettering Breast Evaluation Centers
Kettering Cardiovascular Institute
Kettering Medical Center Foundation
Kettering Reproductive Medicine
Kettering Sports Medicine Center
Kettering Sports Medicine at Tipp City
Kettering Women's & Children's Services
Sycamore Glen Health Center
Sycamore Primary Care Center
Wallace-Kettering Neuroscience Institute
Wellness On Wheels
Wound Health and Hyperbaric Medicine Center

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

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

Dear Administrator McClellan:

I am concerned and oppose the proposed rule to significantly reduce Medicare reimbursement to long term acute care hospitals.

I work at an acute care hospital that relies on the specialized support and expertise of a long term care hospital in our community. Their expertise helps these patients recover quicker and return to a productive life.

The proposed rule will have a devastating impact on patient access to critical care, and will likely force many long term acute care hospitals to close their doors due to the significant payment reductions. It will likewise increase our length of stay for critical patients and the overall cost of patient care.

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

Sincerely,

Richard Haas
Senior Executive Officer

RH:jj

American Hospital Association

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Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

Rec'd 3/20/06

March 20, 2005

MAR 20 2006

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

RE: 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 American Hospital Association (AHA), on behalf of our 4,700 member hospitals and health care systems, and 31,000 individual members, appreciates the opportunity to comment on the proposed rule concerning the long-term care hospital prospective payment system (LTCH PPS) for rate year (RY) 2007. The proposed rule recommends several significant changes that are of concern to the AHA – most notably the proposal to omit the 3.6 percent market basket update and to change the short-stay outlier (SSO) policy. The alarming net impact of this proposal – a 14.7 percent cut in Medicare payments – is excessive and would severely and inappropriately threaten patient access to LTCH care.

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

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

Annual market basket updates are intended to compensate for year-to-year inflationary increases in the cost of delivering health care services. An annual inflationary update to the LTCH PPS, and all prospective payment systems, is essential to maintaining an accurate payment system that helps providers safely care for patients. As such, it is wholly inappropriate to exclude a market basket update for LTCHs in RY 2007, as recommended by the proposed rule. The RY 2007 market basket calculation of 3.6 percent under both the RPL market basket method and the current methodology validates the real inflation costs LTCHs will face next year, which must not be overlooked in the final rule. In addition, to omit the market basket update to offset coding changes is a misuse of the market basket.

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

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

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

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

- the full LTCH DRG payment;
- 120 percent of the LTCH DRG per diem; or

- 120 percent of the cost of the SSO case.

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

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

The proposed SSO policy falsely equates a short-stay outlier case with 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. The agency 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. **The LTCH SSO policy should not be adopted as proposed. CMS' proposal is based on the unsubstantiated view that all SSO cases are inappropriate admissions and it would penalize LTCHs for treating patients who are clinically appropriate for the setting.**

CMS also states that by treating SSO cases, LTCHs may be "functioning like an acute-care hospital." But CMS has overlooked essential differences between the LTCH and inpatient PPS case mix. For instance, The Lewin Group has compared DRGs in the LTCH and inpatient PPS system that are the same and found that the case-mix index for LTCH SSO cases is more than double the case mix index for general acute hospitals.

A dramatic difference also is found when comparing ALOS. LTCH SSO cases have an ALOS that is more than twice as long as the ALOS for inpatient PPS hospitals, 12.7 days versus 5.6 days, respectively. Analysis by Avalere Health found that among the LTCH and LTCH SSO populations, the presence of the highest levels of medically complex patients is nearly double what is found in the general acute hospital population. This directly challenges CMS' assertion that all SSO cases result from intentionally inappropriate transfers to LTCHs and makes a clear case that the **patients treated in LTCHs, including SSO cases, are sicker than the patients treated in general acute hospitals.**

These analyses of patient severity and cost 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 SSO cases is unjustifiable since it is in direct violation of the Medicare principle of establishing payments based on the average cost of treating specific types of**

patients. And in this case, the LTCH and general acute populations are distinctly unique from one another.

AHA Recommendations

Recent LTCH growth is being watched closely by Congress, CMS and others. **Any proposed efforts to slow LTCH growth should be based on balanced and thoughtful policymaking that ensures access for patients for whom LTCH care is medically appropriate.** Adding criteria to the current 25-day ALOS requirement would be a major improvement in focusing LTCH care on specific populations. 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. **Balanced approaches, discussed in greater detail below, should be used rather than blunt policies such as the current cap on host-hospital referrals for co-located LTCHs and the proposed SSO policy changes.** Both of these policies fail to focus on the clinical characteristics and needs of patients and instead rely on overly broad, non-clinical proxies (LOS and referral source) to determine whether an LTCH admission is appropriate.

We fully support the June 2004 recommendation 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 will work with CMS and other LTCH organizations to use the RTI findings as a basis for expanding the current LTCH criterion. This should be a top priority for CMS and others concerned about rapid LTCH growth.**

We also 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 LOS or referral source. When reviewing LTCH cases for medical necessity, QIOs apply professionally developed criteria; an assessment of the appropriate medical care available in the community; and national, regional and local norms. QIO review also includes safeguards that protect the interests of Medicare beneficiaries. Under the

QIO review process, beneficiaries and their physicians are eligible to discuss a particular case with the QIO reviewer prior to a determination. In addition, the QIO reviewer is required to explain "the nature of the patient's need for health care services, including all factors that preclude treatment of the patient..." QIO review also includes appeal rights for beneficiaries. This system would be clinically-focused and therefore a more effective means of ensuring appropriate patients are treated in LTCHs than the agency's SSO proposal and the current policy pertaining to host-hospital referrals to co-located LTCHs.

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

The proposed SSO changes wrongly assume that the SSO population is homogeneous. The SSO population includes cases with LOS ranging from one day to 54 days, and some even qualify for LTCH high-cost outlier status. **Given this wide variability, all SSO cases should not be treated the same under the LTCH PPS. CMS should change the way it identifies and pays for SSO cases and implement the following SSO changes:**

- Establish a method for identifying a subset of SSOs – very short-stay cases – to ensure there is no incentive to transfer patients who may be near death.
- This subset of very short-stay cases should be paid at 100 percent of costs.
- LTCH cases with a LOS greater than 20 days should be removed from the SSO definition. Any case of such a substantial duration is not suitable for reduced payment. Cases with LOS in this range are consistent with the population intended for the LTCH setting and should be eligible for the full LTCH DRG payment.
- Remaining SSO cases should continue to be paid under the current SSO policy.

The AHA appreciates the opportunity to comment on this proposed rule. We are committed to improving the LTCH PPS and look forward to working with CMS toward this goal. To discuss any questions or reactions to our comments, please contact me or Rochelle Archuleta, senior associate director of policy, at (202) 626-2320.

Sincerely,

Rick Pollack
Executive Vice President