#8

TEXAS HOSPITAL ASSOCIATION

March 7, 2006

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

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

Dear Dr. McClellan:

On behalf its 430+ member hospitals, the Texas Hospital Association offers the following comments on the proposed rules published Jan. 27 at 71 *Fed. Reg.* 4648 et seq. All Texas hospitals rely on long-term care hospitals as a critical part of the state's health care delivery system. Texas patients and acute-care hospitals, as well as LTCHs, are harmed by this proposal. The rules force changes in the admission practices of LTCHs and implement punitive payment policies. LTCHs treat severely medically complex patients and offer specialized services not appropriately provided in other settings.

The proposed short-stay outlier rule and zero-update proposals reduce payments to LTCHs in fiscal year 2007 to a level that they could not continue to care for Medicare patients. THA urges CMS to consider the implication of denying the services of LTCHs to Medicare patients. Denying access to LTCH services could have very serious consequences to patients and taxpayers as these patients are left to other long-term care alternatives with little hope of fully independent living.

The CMS short-stay outlier and market update proposal continues the trend of degrading payment system integrity to reach budgetary and policy objectives. THA respectfully urges CMS to reconsider these proposals.

Sincerely,

Ernie Schmid

Ernie Schmid, FACHE
Senior Health Care Policy Analyst

Serving Hospitals and Health Systems
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March 10, 2006

VIA OVERNIGHT DELIVERY

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: CMS 1485P, "Other proposed policy changes for 2007 LTCH PPS Rate Year, Proposed Adjustment for Specific Cases, Adjustments for SSO Cases"

Dear Administrator:

This letter represents certain comments and recommendations from Triumph HealthCare to key aspects of the proposed annual payment rate updates, policy changes, and clarifications under the prospective payment system for long-term care hospitals (LTCHs) for FY 2007. I have outlined below the fundamental issues which we believe to be severe and arbitrary.

Although there are many policy changes proposed and contemplated in this proposed rule, and I will have additional comments on those in a later letter, this letter will focus entirely on the "Adjustment for SSO Cases and Proposed Changes to the Method for Determining the Payment Amount for SSO Cases." My attention in this letter will focus primarily on the use of Short Term Acute Hospitals (STAC) IPPS system for Short Term Outliers (SSOs) of LTCHs, or as CMS refers to it, a payment system comparable to STAC IPPS.

When congress originally excluded LTCHs from IPPS in 1983 (and CMS originally issued regulations for LTCHs) they were excluded because of the vastly different types of patients treated and resources consumed. Specifically, CMS stated that this exclusion from IPPS was because the use of IPPS for LTCH "would be inaccurate and unfair" and was "not designed to account for types of treatment" found in LTCHs (Aug. 31, 2002 FR, Vol.67, No.169, p.55957). CMS itself in 2002 said that applying IPPS to LTCHs could "systematically underpay" LTCHs "if the same DRG system were applied to them." (August 31, 2002 Fed. Reg.)

With the proposed rule, CMS is now completely reversing position and proposing that LTCHs be paid IPPS rates for 37% of the patients treated in LTCHs (SSOs). Clearly when 37% of patients are paid a rate of less than 43% of the actual costs to provide care, hospitals will suffer severely, and ultimately so will patients, families, nurses, physicians, and the community at large. *This*

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proposal will endanger the most vulnerable and fragile patients in our society and likely the industry as a whole. CMS is proposing to pay LTCH IPPS rates for SSOs based on faulty assumptions, insufficient data, and a fundamental lack of understanding of the valuable care provided by LTCHs across the country.

This proposal is based upon numerous erroneous assumptions such as:

1. **LTCHs are taking "premature and inappropriate" patients that have not received their full care from the STAC.**

In fact, admissions to LTCH from STAC hospitals actually had over double the average length of stay in the STAC hospital than the STAC average for those same DRGs. Specifically, patients admitted to an LTCH from a STAC hospital averaged more than a 13-day stay in the STAC before admission to LTCH vs. the geometric mean of those same DRGs in STAC of 6 days. Therefore, LTCH patients had twice as long a hospitalization as normal in the STAC to receive their normal amount of care before admission, a direct contrast to the "premature and inappropriate" accusation. In addition, since the 2004 Medpar data that was used in this analysis, CMS has added an additional 200 DRGs under the Transfer Regulations that will further discourage STACs from making premature discharges to LTCH. The impact of the additional transfer DRGs was not even considered in this proposed rule. Even though these SSO patients have had an extensive stay in STAC before admission to LTCH they are still severely ill. Under the new AP-DRG system the percentage of severely ill patients in LTCH is double that of the STAC, 66%LTCH vs. 33%STAC (% of APDRG Severity of Illness (SOI) categories 3&4)

2. **LTCH SSOs are predictable and hospitals are admitting them because of an "inappropriate financial incentive" and are admitting patients "with lengths of stay more typical of an acute care hospital."**

In fact, average length of stay for SSOs in LTCHs is 13.1 days vs. geometric mean length of stay (GMLOS) in STAC for the same DRGs of 6.1 days. Therefore, the LTCH patients have a length of stay averaging over twice the length of stay in STAC for the same DRG. The patients being admitted to LTCH are not the same and should not be treated the same as the general population of the STAC.

A significant portion of LTCH SSOs are patients that unfortunately, and unexpectedly, die. For Triumph, 24% of our SSOs are attributable to deaths. The faulty assumption has been that LTCHs can predict deaths and are taking these SSOs intentionally. *This could not be further from the truth.* Because of the severity of illness of LTCH patients and the number of co-morbidities, the predictability of length of stay and death is much less accurate than in STAC. In fact, even in STAC there are a large number of early deaths when compared to GMLOS. While clinicians may exercise sound judgment and have "gut feels", there are no accurate tools available for predicting mortality in an LTCH setting. The need for LTCHs to exceed the 25 day

LOS also undercuts the argument that LTCHs intentionally take short stay deaths. LTCHs sometimes unexpectedly have a 25-day problem. Almost always it is because of unexpected deaths.

The patients are severely ill with 66% of SSOs in LTCHs in AP-DRG severity of illness categories (SOIs) of 3(major) or 4(extreme) compared to STAC average of 33%. LTCH patients average at least one more co-morbidity than the STAC average and patients are two years older than even the average age of outliers in STACs.

Additionally, more than 10% of Triumph SSOs were already outliers in STAC before admission to LTCH, certainly not early discharges from a STAC facility. More than 7% of SSOs had greater than a 25-day length of stay, hardly a typical stay at a STAC facility.

3. **37% of patients in SSOs is "inappropriately high."**

CMS utilized FY 2004 Medpar data to develop the payment policies included in the proposed rule, which only reflected the first year of transition into PPS for LTCHs, and a substantial number of LTCHs had not even fully transitioned to PPS in FY 2004. With one year of data, CMS concludes that SSOs in LTCHs have dropped from 48.4% to some 37% one year post transition to PPS. A drop from over 48% to 37% would hardly suggest that the payment policies in place were not having the desired effect. Recent data released by Lewin shows that STACs have 40% of their cases shorter than 5/6 of their GMLOS, so is this inappropriately high? Of course not, it is the nature of the bell curve and the PPS system that some patients fall below and some fall above the mean. A cutoff was chosen (5/6) related to the cost methodology (120% of cost) and the desire not to create a cliff. Then the original % was noted (48.4%), then the drop was noted (37%), and then a new formula was created (IPPS for SSOs) *based on no identifiable data or appropriate methodology*. Even though the lengths of stay compared to STAC are more than double, the severity of illness in LTCH is also double that of STAC. Many cases are already outliers in STAC before admission to LTCH, many SSOs are unpredictable deaths and a sizable number have more than a 25-day length of stay in LTCH, yet CMS proposes to pay LTCHs via a system developed for a completely different patient population.

Assessment of IPPS for LTCH

This payment methodology also will create a "cliff" (just what CMS did not want to do) just before the 5/6 point because it is based on STAC IPPS which has a very short GMLOS. The average length of stay in STAC is 5.3 days versus LTCH of over 25 days. The proposed payment methodology would generally pay a full IPPS DRG payment at 6 days and no additional payment until the 5/6 point or at least 22 days. That is 16 days without additional reimbursement. The vast majority of these patients do not hit outlier status in LTCHs (81% of SSOs will be paid under proposed IPPS) and the closer they get to the 5/6 the lower the payment per day is until the difference (between full pay and IPPS pay) the day before the full LTCH

DRG is the largest "cliff". This is directly contrary to your own opinion (71 FR 4686) where you state supportively that the cost methodology "which results in a gradual increase in payment as the length of stay increases without producing a payment "cliff" at any one point, provides a reasonable payment option under the SSO policy." The IPPS methodology when applied to SSOs creates exactly this cliff the longer the patient stays past the GMLOS for STAC and the closer they get to 5/6. We have already established that the average length of stay for SSOs is over double STAC GMLOS. The interaction of the lower of cost or IPPS will result in the perverse financial incentive of maximizing SSO reimbursement at the geometric method length of stay for STAC or around 6 days. **Given your theory of "inappropriate financial incentives" you should expect average SSO length of stay to be around 6 days in LTCHs based on this perverse economic incentive.**

The result will be limiting access to care for any type of diagnosis/treatment that might have a long stay but has a substantial portion of that type of patient having a 17-18 day length of stay, such as ventilator (DRG 475). Too many of these SSOs will cause a hospital to go under even though the majority might meet the GMLOS and those that missed only missed by a few days. *The most fragile, older, most unpredictable, and most vulnerable patients would be the most at risk.* SSO patients are older, sicker, more intense, more unpredictable, more likely to die and thus are the types of patients LTCHs are supposed to admit and care for. However, a significant percentage have the unfortunate problem of unexpected death or other unexpected outcomes.

Even though a cursory analysis of the data would prove the above points, CMS is proposing paying LTCHs on average 43% of costs for SSOs. In fact, the longer the stay the less the pay per day. The reason we admit them now is not because of our "inappropriate financial incentive" or desire to get "premature and inappropriate" admissions but because these patients need our specialized care, are no longer appropriate for STAC, and we believe that they would benefit clinically from our services. Although our SSO patients are sicker and length of stay is twice as long as STAC, we would be paid less per day the closer the patient gets to the LTCH GMLOS.

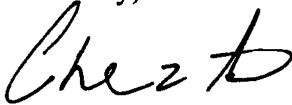
Alternatives and Conclusion

CMS should implement a method as proposed by MEDPAC designed to tighten clinical and facility criteria to address the concerns about clinical appropriateness. Triumph and the industry as a whole are concerned about this as well. We would welcome the chance to work together with CMS on this issue. CMS should release and use the RTI analysis to develop proposals rather than initiating this vast change without this study. If CMS is concerned about very short stays it should use a variation on the original proposed regulation on LTCH PPS which is to have a separate, lower payment for up to 7 day stays. That is, pay a lower percentage of cost for these very short stays as is done for high cost outliers. CMS should use the cost methodology for all SSOs even though we don't find it desirable. It is, however, much better and more appropriate for SSOs, relates to length of stay, and does not create a cliff as STAC IPPS does. QIOs should be held to their responsibility of enforcing clinical criteria and monitoring LTCHs to ensure

appropriateness. We believe the combination of the above alternatives would slow the growth of the industry, meet many of CMS's concerns, and ensure the appropriateness of patients in LTCHs as well.

In closing, CMS should work with the industry, not seek to destroy it.

Sincerely,



Charles L. Allen
President/Chief Executive Officer

CLA/dkl

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TOM COLE
4TH DISTRICT, OKLAHOMA

COMMITTEES:
RULES
ARMED SERVICES
STANDARDS OF
OFFICIAL CONDUCT

MAR 10 2006
10:27AM

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Congress of the United States
House of Representatives
Washington, DC 20515–3604

PLEASE REPLY TO:

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☐ 711 SW D AVENUE
SUITE 201
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(580) 357-2131

☐ 104 EAST 12TH
ADA, OK 74820
(580) 436-5375

February 15, 2006

Administrator Mark B. McClellan, MD PhD
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8013
Baltimore, MD 21244-8013

Dear Administrator McClellan:

It has been brought to my attention that a proposed rule, concerning long term care hospitals, will adversely affect health care cost and delivery in Oklahoma.

The proposed rule will not give long term care hospitals an inflationary update to keep up with the rising cost of care, but will instead cut hospital payments by 15 percent. Since this rule would create a gap between CMS payments and the cost of care, I am very concerned it will have a negative impact on patients who need the services long term care hospitals provide.

I am also concerned that the proposed rule rests on a faulty premise. I believe there is a legitimate question as to whether there is in fact a problem that lines up with the proposed solution. long term care hospital patients are typically admitted after applying a quite rigorous admissions screening process. Revised certification criteria, which would ensure that long term care hospitals are treating only the most appropriate patients - those with the most medically complex conditions - would be a less blunt instrument than a large payment cut, and also more likely to achieve the intended goal.

Long term care hospitals are an important component of our nation's health care system. This rule will inadvertently harm the patients they serve. In light of this, the proposed rule should be either withdrawn or amended so that Oklahoma and other states with similar needs are not unduly and disproportionately impacted.

Thank you for your attention to this matter. Should you have any questions, please do not hesitate to contact me or my health aide, Brad Watson.

Sincerely,

Tom Cole
Member of Congress

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BAY
SPECIAL CARE HOSPITAL

March 8, 2006

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

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

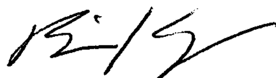
Dear Doctor McClellan:

As Chief Financial Officer of Bay Special Care Hospital, I am very concerned about the financial risk the Medicare Program – 2007 proposed update rule published at 71 Federal Register 4648 *et seq.* will impose upon our long-term care hospitals (LTCHs). The proposed changes to the admission practices and reimbursement policies of LTCHs will significantly reduce payments to Bay Special Care Hospital in fiscal year 2007 by approximately 15 percent. Margins are needed at Bay Special Care Hospital to support hospital modernization, to refurbish, and to keep current with emerging technologies. Bay Special Care Hospital serves a significant percentage of Medicare patients residing in Bay County, Saginaw, Midland, and surrounding counties. Therefore, I urge you to not adopt the proposed short-stay outlier rule and zero update proposal because of the adverse impact it will have on our community and the patients we serve.

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

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

Sincerely,



Brian A. Kay
Chief Financial Officer

/cm

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March 14, 2006

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

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

Dear Dr. McClellan:

The New England Sinai Hospital, located at 150 York Street, Stoughton, MA, submits these comments on 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.

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A Teaching Affiliate of Tufts University School of Medicine

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. The New England Sinai Hospital urges 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, New England Sinai respectfully requests 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,

Lester P. Schindel, CEO and President

RML
SPECIALTY HOSPITAL

March 14, 2006

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

RE: CMS-1435-P

Dear Dr. McClellan:

RML Specialty Hospital (RML) is pleased to have the opportunity to present comments on the Prospective Payment System for Long Term Care Hospitals RY2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarifications.

By way of background, RML Specialty Hospital (RML) is a freestanding hospital licensed in the State of Illinois. RML is a 501(c)(3) not-for-profit limited partnership, whose members are Rush University Medical Center and Loyola University Medical Center. RML's clinical focus is on ventilator weaning (respiratory), complex medical, and wound services. Because of these programs, RML has traditionally maintained a high case mix (one of the highest in the country). During the last 12-months, our overall case mix index fluctuated between 1.75 and 2.05 for Medicare patients. Patients treated at RML are referred from approximately 60 hospitals in Illinois. These patients primarily come from ICUs, critical care units, burn units, and step-down units.

This letter will briefly review recommendations, concerns, and questions that RML has regarding the proposed rule.

1. Although not included in the proposed rule, as I have suggested in the past, I believe there is still a need for the development of a "site of service differential" for LTCHs as part of the LTC-PPS. A site of service differential would recognize the inherent operating and capital expense differences between freestanding LTCHs and hospitals-within-hospitals. In prior LTC-PPS proposed updates, CMS has suggested they are concerned about compensating the host hospital and hospital-within-hospital for overhead and capital associated with the space that is being leased. As you are well aware, the current LTC reimbursement system does not recognize the structural and organizational differences between the two types of LTCHs. A site of service differential would recognize these differences and could provide a better alignment between the resources provided and reimbursement.

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2. Several times within the proposed rule, it is stated that Section 123 of the BBRA requires the LTC-PPS to be a per discharge system, with a Diagnosis Related Group (DRG) based patient classification that reflects the difference in patient resources and costs in LTCHs, while maintaining budget neutrality. An 11.4% drop in reimbursement along with a 0% market basket update cannot be a budget neutral position. This is a significant change in reimbursement from one year to the next, and will do grave harm to LTCHs across the country.

3. LTC-DRG Classifications and Relative Weights – The proposed capital weight methodology may be skewed. It is noted that depreciation cost weights for IRF, IPS, and LTCHs are smaller than those for Children and Cancer hospitals. I suggest that another analysis be done that would isolate freestanding LTCHs from hospital-within-hospital LTCHs and IRFs. Since most LTCHs are units within hospitals, the methodology used to determine these weights may be more heavily aligned with a "unit" perspective as opposed to a freestanding hospital perspective. If so, this is not an equitable methodology. Freestanding LTCHs will have higher depreciation costs, which are probably closer to those associated with Children and Cancer hospitals, as opposed to being compared to the other "unit" venues. This difference may also be true in other major cost categories including wages, drugs, and professional liability insurance.

4. Proposed Market Basket Update for the 2007 LTC-PPS Rate Year. A 0% update to the federal rate for the 2007 LTC-PPS Rate Year is not acceptable. This proposal along with the proposed 11% drop in short-stay outlier and high-cost outlier changes, would be so significant that many LTCHs will not survive these changes. Further, Medpac's recent analysis in their March 2006 report to Congress reports that this - 4.2% adjustment is not budget neutral (see pg. 217).

5. Section 2. – Description of a Preliminary Model of an Update Framework Under the LTC-PPS. There is a statement that a Medicare Program safeguard contractor sampled LTCH claims within one LTCH and determined that the majority of the patients were not hospital level patients. If CMS uses one provider as a base for this entire sector, then I strongly urge CMS to fix the problem and remove that inappropriate provider from the Medicare system. An across-the board assumption from one provider should not be used to eliminate this group of providers.

6. Fixed Loss Amount – The proposed fixed loss amount of $18,489 for the 2007 LTC-PPS rate year is a 76% increase in the amount from the current rate, which is set at $10,501. The explanation for this proposal is that a regression analysis showed that additional increments of outlier payments over 8% (that is, raising the outlier target to a larger percentage than 8%) would reduce financial risk, but by successively smaller amounts. I urge CMS to look at exempting out LTCH providers who have high case mix levels (i.e., over 1.5) from this policy since they are more likely to have high cost outliers. As an institution, RML is currently loosing over $800,000 per year on Medicare high cost outlier patients.

In our last twelve months, we had 53 Medicare high cost outlier patients. Under this proposal, we would lose an additional $530,000 on these same cases. These patients are clinically justified for their long stays. Yet, CMS is placing an unwarranted financial burden for these stays on the LTCH institution. This is not an equitable resolution to this problem. An alternative would be to pay a higher incremental amount (i.e., 90% or 100% of costs) once a patient reaches the high cost outlier threshold.

7. Under Section 6.6 – One Time Prospective Adjustment to the Standard Federal Rate. I have no comment on this section. However, it states that the Secretary has broad discretionary authority in implementing changes to the LTC-PPS System. In previous comments, I have requested that the Secretary review the possibility of providing an additional add-on payment to LTCHs who serve high volume dialysis patients. I request a further review of this request.

8. Short-Stay Outlier – It is suggested that an inappropriate number of patients are being treated in LTCHs who most likely do not require the full measure of resources available in a hospital that has been established to treat patients requiring long stay hospital level care. At no point is it indicated what CMS believes is the appropriate level for short-stay outlier patients in an LTCH. The move from 120% costs to 100% of costs as the short-stay outlier methodology is not acceptable. Alternatives to this would be to move it to 110% of costs. Expirations should also be excluded from the policy change.

9. CMS states that short-stay outliers currently account for 37% of the admissions in LTCHs. It may be worthwhile to reconsider the previously proposed concept of "very short-stay outliers".

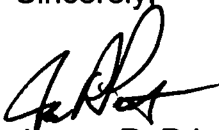
10. 3-Day or Less Interruption of Stay – A statement was made that the number of cases that fell within this category represent only a small number of LTCH hospitalizations and, therefore, they should not be a significant cost for LTCHs to cover these cases "under arrangement." While the first part may be correct, the second part is not. These cases have historically been sent out and were not part of the base rate calculation. If the numbers are small, as is suggested, then why isn't the policy left alone? If CMS believes some of the "problems" are due to LTCH claims, including surgical procedures performed during the prior acute stay, then CMS should correct the problem through focused audits and not suggest eliminating this policy.

11. General Comment - I suggest that LTCHs who want to admit "rehabilitation" cases should be allowed to do so but should be reimbursed using the rehabilitation reimbursement system. If not, then freestanding LTCHs should be allowed to establish distinct part unit rehabilitation units.

Although not a part of the LTC-PPS, there is another proposed change in the short-term PPS system that could have a dramatic impact on LTCHs; that is the proposed change to the Medicare bad debt policy. The proposed policy would have a disproportionate impact on LTCHs because of our long lengths of stay and the fact that LTCHs will utilize co-insurance and lifetime reserve days much more frequently than short-stay hospitals. I suggest that CMS exclude long-term hospitals from this proposed regulation.

I appreciate the opportunity to comment on the proposed rule and CMS's willingness to request input from providers. I strongly urge CMS to re-evaluate its proposal because of the consequences these dramatic proposals will have on LTCH providers. RML is willing to work with CMS to explore these issues in more detail and to assist CMS in gaining a first-hand knowledge of the impact these proposed changes may have on an organization. RML is also willing to work with CMS to explore and develop quality measures for LTCHs as was suggested in Medpac's March 2006 report.
If we can be of assistance, please do not hesitate to call upon us. I can be reached at (630) 286-4120.

Sincerely,



James R. Prister, FACHE
President/CEO

JRP/dmg

Attachment

14

MAR 17 [illegible]

Rod Laughlin, *President & CEO*

March 15, 2006

BY 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
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Dear Dr. McClellan:

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

Regency supports and endorses the comments on the proposed rule which were sent on March 13, 2006 to CMS by ALTHA (the Acute Long Term Hospital Association).

The arbitrary payment reductions CMS has proposed will hurt the care that LTAC patients can receive. Hospitals can't provide care below their cost on a widespread and ongoing basis. If the short stay outlier payment revision is adopted, there will be numerous patients who need LTAC level care, who will simply not receive it.

A far better approach to regulating LTAC hospitals is the adoption of admission criteria, which will insure that appropriate patients are treated in LTAC hospitals. The admission criteria should insure that only patients who can't be treated in a SNF or rehab hospital are treated in LTACs. These admission criteria will help reduce cost in the LTAC sector because eligible patients would be defined and limited. These criteria will slow the growth of LTAC hospitals, especially in markets where there are more than one LTAC hospital. Finally, there would be no need for the 25% quota rule related to the quota of patients that can be admitted from the host hospital. The admission

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criteria would insure that appropriate patients are treated in the LTAC and it won't matter from where the referral originates.

I. Proposed Changes to Short-Stay Outlier Payments

The proposed rule would revise the payment adjustment formula for SSO patients. SSO cases are defined as LTAC 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 (l) 120 percent of estimated 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 LTACH 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 LTAC 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, LTACs could be paid by Medicare under the LTAC PPS at a rate that is more consistent with the rate paid to acute care hospitals when the LTACs treat shorter stay patients.

Response

First, the definition of short stay outliers is far too broad for the proposed payment change. If CMS wants to reduce SSO patients that stay seven days or less and reduce the payment below the cost of treating these patients, that is one thing. Doctors and hospitals might be reasonably expected to identify patients who will only need a short stay.

There is simply no way for doctors and hospitals to predict who will become a SSO patient. Often patients miss the 5/6 target by only a day or two. It is in everyone's interest for patients to be discharged or moved to a more appropriate setting when warranted and LTACs should not be penalized for this by the payment methodology.

The CMS proposal reduces cost too dramatically. The proposed rule reduces costs by approximately 11 percent. Added to that is the freezing of the update factor which CMS estimates to be 3.6 percent. This is at least a 14.6% reduction.

The patients that LTACs treat, even most of the SSO patients, are very sick – much sicker than the average patient in a short term hospital. These LTAC patients have not responded in a short term hospital. It is unreasonable to expect an LTAC hospital to deliver the necessary care to these very sick patients that will get a positive outcome but for the same payment as the short term hospital. That is simply not realistic.

We deliver between 8-12 hours of nursing care per patient day depending on a particular patient's activity needs. We also offer about 5 hours of respiratory therapy per patient day for respiratory patients. This care is necessary to make a difference for these multi-system failure patients.

Most of our patients have co-morbidities that require this staffing and intervention. To cut our reimbursement so drastically, will insure that many of these patients can't be treated in the LTAC setting – even though this care is essential if they are to get their lives back.

As ALTHA stated, certainly CMS is well aware that the rate of payment for these cases will be insufficient to cover LTACs' reasonable and necessary costs in providing care to SSO patients. Although apparently intended to punish LTACs for allegedly inappropriately admitting patients not in need of LTAC care, CMS has produced no study or analysis showing that inappropriate admissions constitute a material portion of SSO cases.

Recommendations

Regency firmly believes that CMS should not revise the payment formula for SSO patients as proposed. These changes are not valid based on the data presented by CMS in the rule. We know that the majority of SSO patients need LTAC level care even if for only several weeks. The LTAC PPS is based on averages. Some patients will require longer stays and some will be shorter. Rather than worrying about length of stay or where the patient was referred from, you should adopt appropriate admission criteria that will insure that the right patients are in the LTAC in the first place.

If CMS insists on using payment methodology to reduce SSOs, then the approach should be based on a more narrow definition of SSO. CMS should define SSOs as patients staying less than 7 days. Those cases could be reimbursed at cost to disincentivize hospitals from admitting those cases. Patients that stay between 7 days and the 5/6th geometric mean for their DRG should be paid as they are presently since most of these are in need of LTAC care for at least some time, and it is essentially impossible to "guess" that someone will not need the full 5/6 length of stay.

I could go on and on with comments regarding the proposed rule – there is so much that is wrong with the approach. ALTHA has summed up most of the comments I would offer and Regency totally supports ALTHA's comments and analysis. I have attached a copy of ALTHA's comments to those of Regency.

Summary

CMS needs to take a different methodology to regulate LTAC PPS than using arbitrary and draconian payment cuts to achieve its policies. CMS should define SSOs as 7 days or less and modify payment policy to cost for those stays. Other SSO stays should be paid under current policy.

CMS should update the 2007 Federal Rate. CMS has reduced the weighting factors on several occasions and admits that LTAC costs are increasing by 3.6%. LTAC hospitals can't treat these very sick patients at reimbursement below our costs.

Finally, CMS should withdraw the proposed rule and develop admission criteria that will more properly regulate the correct patients to be treated in LTACs. That will slow the growth of new LTACs – both Hospital-in-Hospital and freestanding. Admission criteria will remove the need for regulations like the 25% quota rule.

Regency's staff along with ALTHA and other industry representatives are anxious to work with CMS on better proposals to define LTAC patients and to insure that reimbursement is adequate to insure success and quality of care for the sickest and most fragile Medicare patients. Regency seeks to make a difference in the lives of very sick patients that need an LTAC to obtain a better outcome. We are asking for reimbursement that allows us to do our job well. We are getting 50-60 percent of our patients home and we have a very high case mix on a consolidated basis. We want to be a great LTAC company that focuses on quality care and excellent customer service. Please help us to continue to do that for Medicare patients.

Thanks for the opportunity to submit these comments.

Sincerely,

Rod Laughlin, CEO
Regency Hospital Company

14

MAR 17 [illegible]

Rod Laughlin, *President & CEO*

March 15, 2006

BY 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
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Dear Dr. McClellan:

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

Regency supports and endorses the comments on the proposed rule which were sent on March 13, 2006 to CMS by ALTHA (the Acute Long Term Hospital Association).

The arbitrary payment reductions CMS has proposed will hurt the care that LTAC patients can receive. Hospitals can't provide care below their cost on a widespread and ongoing basis. If the short stay outlier payment revision is adopted, there will be numerous patients who need LTAC level care, who will simply not receive it.

A far better approach to regulating LTAC hospitals is the adoption of admission criteria, which will insure that appropriate patients are treated in LTAC hospitals. The admission criteria should insure that only patients who can't be treated in a SNF or rehab hospital are treated in LTACs. These admission criteria will help reduce cost in the LTAC sector because eligible patients would be defined and limited. These criteria will slow the growth of LTAC hospitals, especially in markets where there are more than one LTAC hospital. Finally, there would be no need for the 25% quota rule related to the quota of patients that can be admitted from the host hospital. The admission

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The proposed rule would revise the payment adjustment formula for SSO patients. SSO cases are defined as LTAC 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 (l) 120 percent of estimated 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 LTACH 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 LTAC 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, LTACs could be paid by Medicare under the LTAC PPS at a rate that is more consistent with the rate paid to acute care hospitals when the LTACs treat shorter stay patients.

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First, the definition of short stay outliers is far too broad for the proposed payment change. If CMS wants to reduce SSO patients that stay seven days or less and reduce the payment below the cost of treating these patients, that is one thing. Doctors and hospitals might be reasonably expected to identify patients who will only need a short stay.

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The patients that LTACs treat, even most of the SSO patients, are very sick – much sicker than the average patient in a short term hospital. These LTAC patients have not responded in a short term hospital. It is unreasonable to expect an LTAC hospital to deliver the necessary care to these very sick patients that will get a positive outcome but for the same payment as the short term hospital. That is simply not realistic.

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Recommendations

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Thanks for the opportunity to submit these comments.

Sincerely,

Rod Laughlin, CEO
Regency Hospital Company

attachment for #14

ALTHA, INC.
625 SLATERS LANE
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FAX: 703.518.9980
WEBSITE: ALTHA.ORG
INFO@ALTHA.ORG

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
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Dear Dr. McClellan:

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

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

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

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

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

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

I. Proposed Changes to Short-Stay Outlier Payments

A. General Description

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

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

B. Assessment

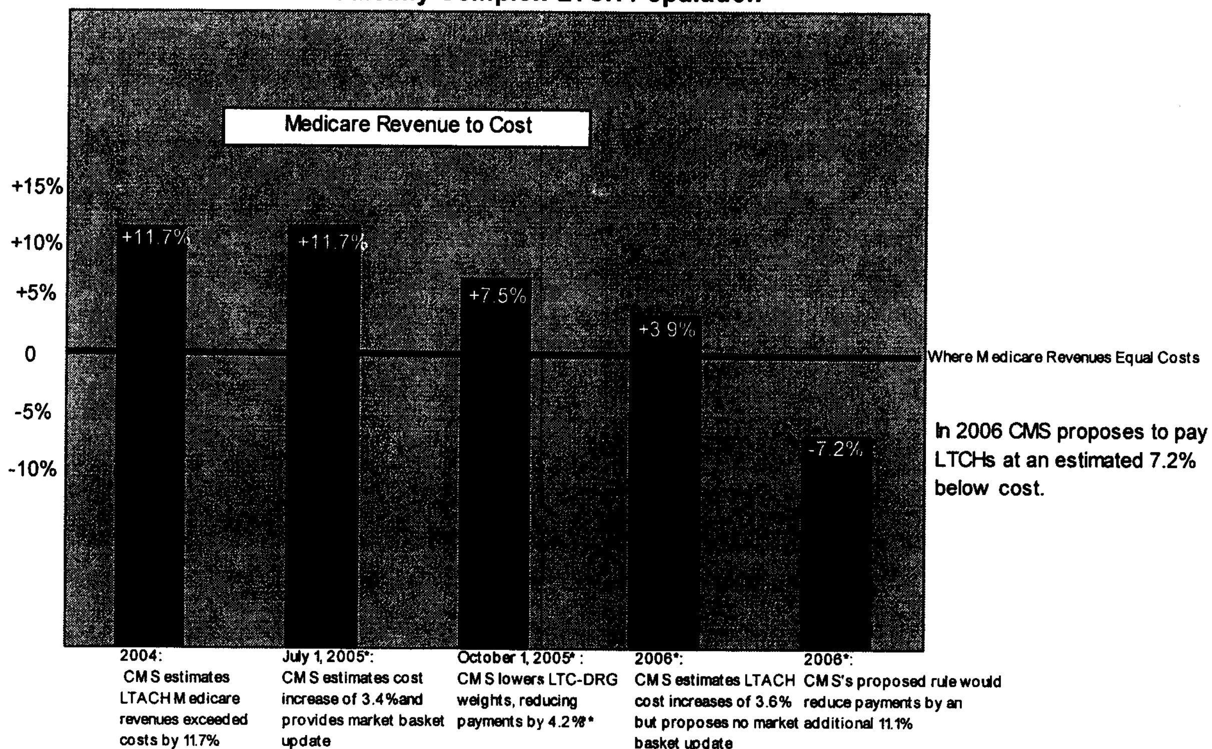
1. CMS's Proposal to Pay for SSO Patients at IPPS Rates Would Result In LTCHs Being Paid Amounts Significantly Below Their Costs of Providing Patient Care

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

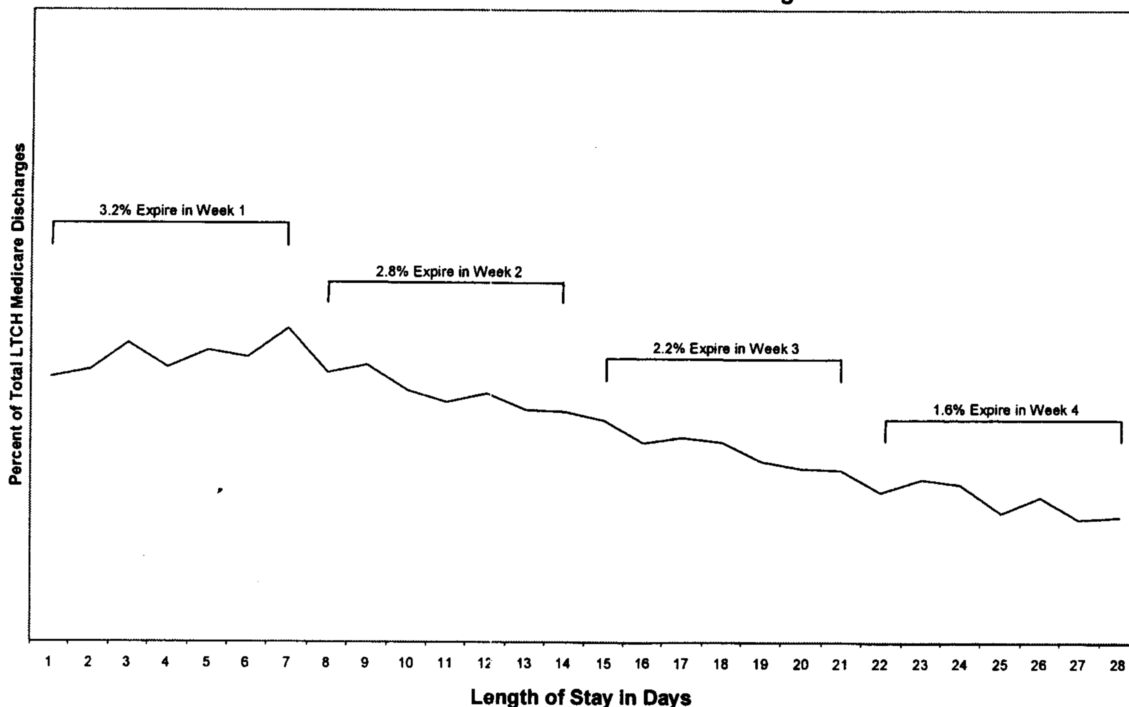
Even if CMS were to find a significant number of SSO cases after most LTCHs had begun to receive payments based in whole or in significant part on the federal rate, CMS would still need to determine from some reliable data source (1) the portion of SSO cases that are patients whose medical condition(s)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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

TABLE 1

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

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

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

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

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

TABLE 2

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

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

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

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

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

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

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

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

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

TABLE 3

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

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

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

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

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

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

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

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

TABLE 4

Comparison of Short-Term, SSO and All LTCH Patients

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

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

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

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

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

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

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

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

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

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

CMS states "[w]e believe that the 37 percent of LTCH discharges (that is, more than one-third of all LTCH patients) that the FY 2004 MedPAR identified as SSO cases continues to be an inappropriate number of patients...." 71 Fed. Reg. at 4,686. However, CMS measures SSO utilization using a methodology that will *always* produce results that are in the same range as the current 37 percent total. Assuming that the GMLOS is defined as the point at which the length of stay of 50 percent of patients are above and 50 percent are below, then taking 5/6th of the GMLOS will consistently produce a percent of patients that is around 42 percent. That is, 5/6th of 50 percent is always 42 percent. As the lengths of stay change each year and the GMLOS is recalibrated annually, the 5/6th 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 $5/6^{th}$ geometric mean threshold for their DRG.

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

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

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

C. Recommendations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

II. Proposal to Not Update the RY 2007 Federal Rate

A. General Description

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

B. Assessment

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

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

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

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

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

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

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

3. The CMS Analysis of LTCH Margins Is Flawed

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

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

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

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

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

> As we explained in the FY 2006 IPPS proposed rule (70 FR 23667), we continue to observe an increase of relatively lower charge cases being assigned to LTC–DRGs with higher relative weights in the prior year. The addition of these lower charge cases results in a decrease in many of the LTC–DRG relative weights from FY 2005 to FY 2006. This decrease in many of the LTC–DRG relative weights, in turn, will result in an estimated decrease in LTCH PPS payments. As we explained in that same proposed rule, contributing to this increased number of relatively lower charge cases being assigned to LTC–DRGs with higher relative weights in the prior year are improvements in coding practices, which are typically found when moving from a reasonable cost based payment system to a PPS.
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> [...]
>
> 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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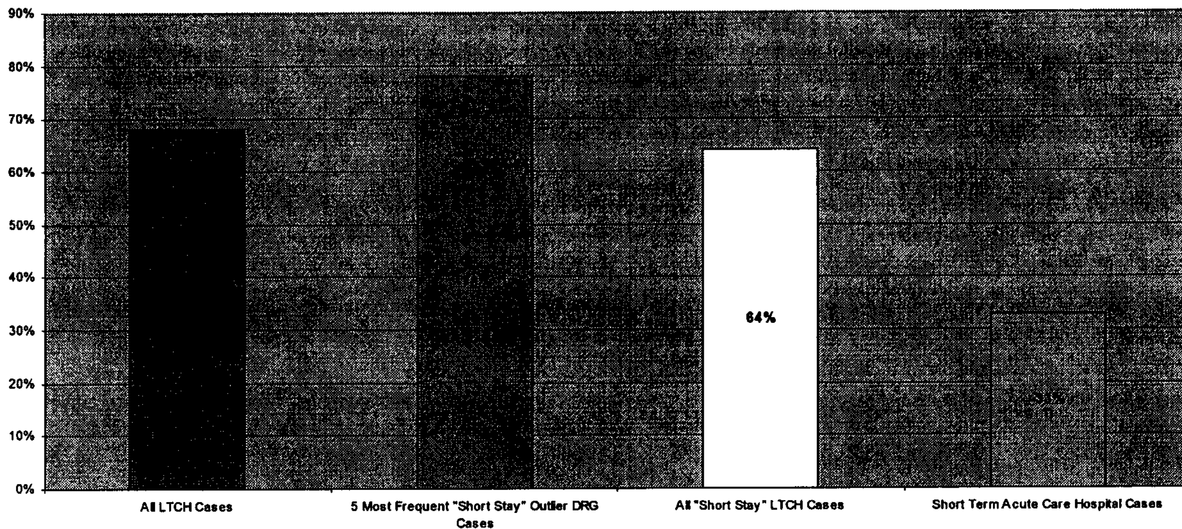
of 3.6%. By reducing the $5.27 billion by the CMS-estimated 11.1% SSO policy effect, and by eliminating the market basket update, spending under existing policies would be $4.5 billion in 2007. CBO estimates of net mandatory Medicare spending in RY 2007 is $383.4 billion, meaning that LTCH spending projections 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**

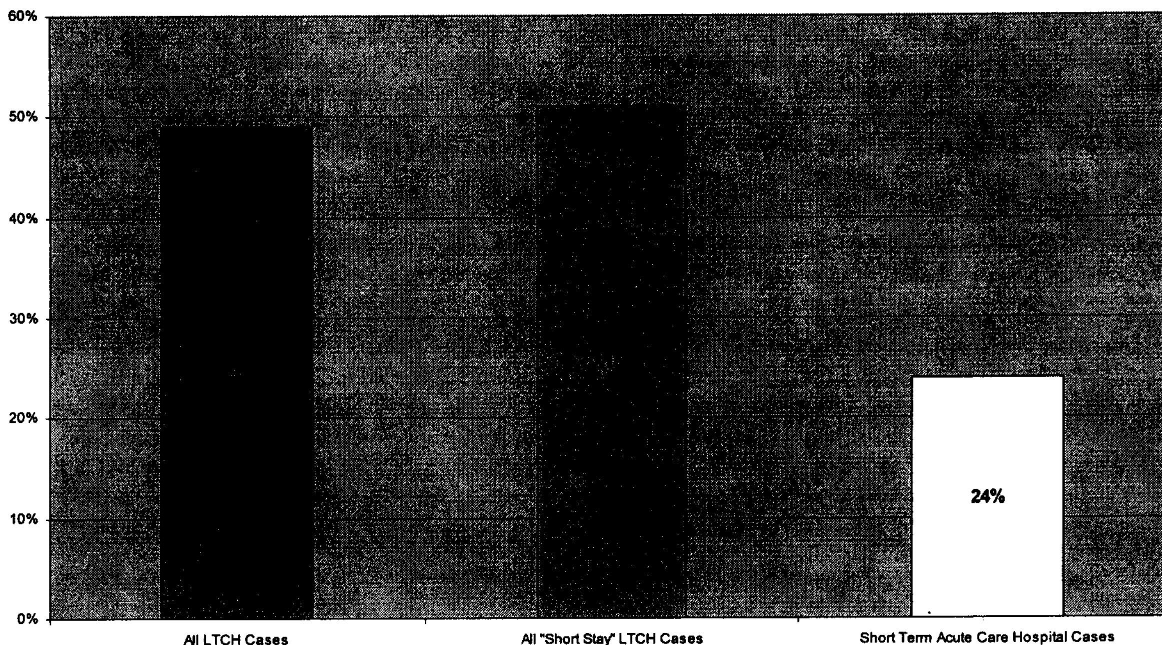
***Severity of Illness from APR-DRG Methodology**

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

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.[9]

TABLE 5

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

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

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

C. Recommendations

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

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

A. General Description

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

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

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

B. Assessment

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

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

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

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

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

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

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

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

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

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

C. Recommendations

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

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

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

V. Postponement of One-Time Budget Neutrality Adjustment

A. General Description

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

B. Assessment

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

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

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

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

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

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

C. Recommendations

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

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

A. General Description

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

B. Assessment

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

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

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

C. Recommendations

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

VII. High-Cost Outlier Regression Analysis

A. General Description

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

B. Assessment

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

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

C. Recommendations

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

VIII. SSO Fixed Loss Threshold

A. General Description

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

B. Assessment

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

C. Recommendations

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

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

A. General Description

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

B. Assessment

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

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

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

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

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

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

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

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

C. Recommendation

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

X. CMS Failed to Accurately Complete the Regulatory Impact Statement

A. General Description

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

B. Assessment

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

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

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

Moreover, CMS's conclusion that it does not anticipate changes in patient quality of care or access to services ignores other recent changes to LTCH coding that would be exacerbated by the proposed 11.1 percent decrease. In the IPPS Final Rule for FY 2006, published August 1, 2005, CMS reduced the LTC-DRG weights in a manner that will result in an agency-estimated 4.2 percent reduction in payments to LTCHs. It is difficult to understand how an 11.1 percent decrease due to changes in SSO payments – when coupled with the already-implemented 4.2 percent decrease from the reweighting of the LTC DRGs and a proposed zero market basket update – will 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, 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

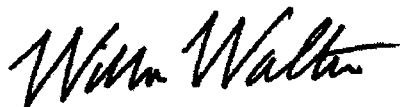
Due to the numerous data errors discussed above, the proposed rule is fatally flawed. CMS must formally withdraw the proposed rule as soon as possible. CMS has asked for comments to the proposed rule by March 20, 2006 and has stated that it will issue a final rule on LTCH PPS for RY 2007 in the Spring 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,



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March 15, 2006

VIA FEDERAL EXPRESS

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007; Proposed Rule 71 Fed.Reg. 4648 (January 27, 2006)

Dear Dr. McClellan:

On behalf of Promise long-term acute care hospitals across the county, Promise Healthcare, Inc. ("Promise") submits the following comments to the Proposed Rule establishing new policies and payment rates for Long-Term Care Hospitals ("LTACHs") Prospective Payment Systems ("PPS") for Rate Year ("RY") 2007.[1] Promise agrees with the Centers for Medicare and Medicaid Services' ("CMS") stated objectives of controlling costs while continuing to make high quality health care available to those most in need. Promise likewise recognizes that such objectives present significant challenges to all facets of the health care industry. Thus, Promise applauds CMS for its conscientious efforts to improve the system, but nevertheless presents the following comments, including some very serious concerns, for CMS's consideration. While Promise understands CMS's need to review regularly the efficiency and economy of its many health care programs, Promise believes that in the case of the January 27, 2006, Proposed LTACH PPS Rule (the "Proposed Rule"), CMS has introduced certain measures and payment principles that are unworkable in practice and, at least at this point, conceptually flawed. We urge CMS to reconsider and at least modify the most flawed aspects of the Proposed Rule.

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[1] Promise owns and manages LTACHs in Baton Rouge, Louisiana, Shreveport, Louisiana, Ferriday, Louisiana, Port Arthur, Texas, San Antonio, Texas, Salt Lake City, Utah, and Phoenix, Arizona, and manages two other LTACHs in Los Angeles, California.

A. Proposed Adjustment for Short Stay Outlier ("SSO") Cases

1. The proposed changes to the LTACH PPS regulations seek to overhaul the payment adjustment formula for SSO patients in a draconian manner.

SSO cases involve situations where a patient receives less or shorter than the full course of anticipated treatment prior to being discharged or, in a not insignificant number of cases, dies early in his or her LTACH stay. CMS identifies SSO cases as LTACH PPS cases with a length of stay of less than or equal to five-sixths of the geometric average length of stay ("LOS") for each long-term care diagnosis related group ("LTC-DRG"). The Medicare program currently pays for SSO patients based on the lesser of (i)120% of estimated patient costs; (ii) 120% of the per diem of the LTC-DRG multiplied by the length of stay of that discharge; or (iii) the full LTC-DRG payment.

CMS has proposed radical changes to the SSO payment methodology in its January 27, 2006, Proposed Rule. First, CMS seeks to reduce the first alternative of the current payment formula from 120% to 100% of the costs of a case. Second, CMS proposes to add a fourth component to the present formula that would allow for payment under the LTACH PPS based on an amount "comparable" (but not necessarily equivalent to) what would be paid to an acute care hospital under the Inpatient Prospective Payment Systems ("IPPS"). Thus, under the proposal, LTACHs would in the future be paid based on the lesser of four (instead of three) amounts, the lowest of which, in many if not most cases, would be an amount comparable (though not necessarily equivalent) to the IPPS payment for that patient's stay. Both changes are designed to be effective for discharges on or after July 1, 2006.

CMS apparently believes that SSO cases are too prevalent in the LTACH system under Medicare, and that payment for SSO cases in LTACH facilities (that is, any case that lasts equal to or less than five-sixths of the geometric average length of stay for a patient categorized within that LTC-DRG) should be paid more consistently with rates paid to acute care hospitals. In CMS's view, at below five-sixths of the average length of stay for a particular LTC-DRG, LTACHS are essentially providing care that should be provided by short-stay acute hospitals. There is no demonstrated support, empirical or otherwise, for so radical and draconian a program change.

2. The proposed SSO methodology is contrary to CMS's 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 is seeking to update reimbursement policies based on a paucity of data, from a very limited period of time, with potentially disastrous results for LTACH providers and the severely ill patients these providers serve.

CMS identifies essentially two sources of data for the most critical changes proposed for SSO cases. CMS claims to have studied LTACH claims data from the fiscal year ("FY") 2004 MedPAR files (using version 23 of the GROUPER software), which CMS indicates states that 37% of LTACH discharges are SSO patients. CMS indicates that it compared this percentage against the 48% of LTACH discharges that would have been SSO patients at the outset of LTACH PPS (i.e., at the outset of FY 2003). After comparing the number of SSO cases for FY 2003 against the number

of SSO cases for FY 2004, CMS indicates that the decrease in SSO cases is insufficient and that further changes must be made to reduce the LTACH SSO case load.

Promise cannot assess whether these percentages are correct; assuming they are accurate, however, it is vastly premature to use this limited set of data to make so drastic and potentially ruinous change to how SSO payments are calculated.

Assuming that the SSO percentage at the outset of LTACH PPS was 48%, and further that many LTACH providers had only a few months of LTACH PPS experience in the first LTACH 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 full year of LTACH PPS by approximately 30%. Moreover, existing regulations provide that each LTACH payment consisted of (no more than) 40% of the federal prospective payment rate during FY 2004, whereas 60% of each LTACH payment was still paid as cost based reimbursement for the many LTACHs that, as of 2004, had chosen to transition to the LTACH PPS and did not convert to the PPS. Thus, the incentives that CMS indicated it built into the LTACH PPS to pay LTACHs for patients who likely could not be more appropriately treated in other types of facilities would not yet have been reflected much at all in FY 2004.

To engage in any credible analysis, CMS must reexamine the remaining number of SSO cases and the more comprehensive LTACH 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 that more than 50% of each LTACH PPS payment could have consisted of the federal rate, and thus could have been subject to a meaningful impact by the existing SSO payment criteria). Only after such analysis can CMS make a rational decision about whether SSO cases remain a material segment of LTACH discharges. The mere fact of a 30% reduction between the onset of LTACH 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. In fact, for many of the reasons stated below, Promise does not believe that the existence of SSOs is an inherent problem, but rather is a normal consequence of treating many patients with a variety of clinical challenges.

CMS also has failed to take into account several other key data points in racing to produce this Proposed Rule. CMS suggests that an inappropriate number of patients are being treated in LTACHs that likely do not require the full measure of resources available in a hospital that has been established specifically to treat patients requiring long-stay hospital level care. CMS suggests that if these patients required the type of care associated with LTACHs, they would most likely have remained in the LTACH facility for the duration of the length of stay associated with the particular LTC-DRG to which the case was assigned. *See* 71 Fed.Reg. at 4686.

Such a view simply ignores available data provided by the Acute Long Term Hospital Association ("ALTHA") 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 LTACHs, but whose condition may have improved enough to warrant further treatment in alternative and less intensive care settings; (2) some portion of SSO cases involve patients who die during their LTACH stay; and (3) some portion of SSO cases may be admitted to an LTACH, 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 LTACH cases are not appropriate for the LTACH level of care.

For example, according to 2004 MedPAR data, 23% of all SSO patients are categorized as SSO cases because of their death while an inpatient at an LTACH. There is absolutely no evidence that SSO patients who expire during an LTACH stay did not require an LTACH 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. Promise does not operate its facilities in a manner that looks for patients who may perish soon, nor does Promise believe that any other operator of LTACHs would seek to "game" the system in such a vulgar 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 LTACH. 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 LTACH patients, when measured by severity of illness 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.

Another segment of LTACH SSO patients are so identified on the basis that their Medicare coverage expires during their LTACH stay, but before they reach the relevant SSO threshold. Loss of Medicare coverage bears no relation to whether the patient was appropriately admitted to an LTACH in the first place. CMS recognized this when it implemented LTACH PPS, deciding to count total patient days rather than Medicare covered days to determine whether an LTACH meets the statutory average length of stay requirement for certification. *See* 67 Fed.Reg. 55954, 55984 (August 20, 2002).

CMS also appears to ignore readily available data concerning QIO reviews of LTACHs. Medicare QIOs conduct post-admission reviews of LTACH patients to confirm that an admission is medically necessary. At CMS's own direction, QIOs have reviewed a sample of LTACH cases for admission appropriateness at numerous facilities, including some of Promise's facilities. Promise is aware that for two of the largest LTACH organizations, QIOs have determined that the vast majority of LTACH admissions were appropriate and medically necessary, with denial rates well under 3%. With respect to QIO review of Promise's facilities, for the past year and a half, less than one case in every 1000 has not been considered medically necessary.

CMS also appears to have ignored the fact of the clear clinical differences between SSO LTACH patients and general acute care hospital patients. When Congress created the separate category of LTACH hospitals in the 1980s, it recognized that LTACHs treat a different patient population from that of general acute care hospitals, and a patient population with few, if any, other treatment options. LTACH patients have been shown repeatedly 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 LTACH patients are not clinically identical or even similar to short-term general hospital patients, regardless of the fact that SSO LTACH patients' lengths of stay is less than the average LTACH patient.

CMS's apparent assumptions to the contrary are not based on any credible data. Data from the 2004 MedPAR file indicate, looking at the most common SSO LTC-DRGs and comparing the average length of stay for those stays with the average length of stay for the average short-term hospital patient (in the same diagnostic categories), that LTACH SSO patient lengths of stay greatly exceed those of patients treated for similar diagnostic issues in general short-term care hospitals. Once again, CMS's proposed changes to LTACH payment policy has not been founded on sound historical data. Looking at it another way, to view the extent to which CMS's proposed approach contradicts the available data and established regulatory scheme, many types of patients classified as "SSO patients" at LTACHs actually have an average length of stay that ***exceeds*** the twenty-five day threshold that CMS uses to determine whether a hospital is eligible for classification as an LTACH 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 LTACHs that admit and treat far more medically complex patients than do short-term general acute hospitals.

CMS also 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 LTACH would not receive a full LTACH 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 of the average 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.

Now, after looking at only one complete year of data, and part of another, CMS proposes to radically alter the methodology for determining payment amounts for SSO cases. In stark contrast to CMS's 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's newly proposed SSO policy proposals are based only on CMS's unsubstantiated assumptions that all SSO patients have been inappropriately admitted to LTACHs or inappropriately discharged from general acute care hospitals.

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, as opposed to making snap judgments based on a quick glance at the first full year of LTACH PPS and LTC-DRG implementation.

3. 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 LTACH patients) who stayed in the LTACH facility twenty-six 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 typical length of stay (which is on the order of eight days). In addition, the patient, despite being classified as a SSO, would actually have stayed in the LTACH facility for longer than the twenty-five day length of stay that has been established by CMS as the basic, underlying requirement for LTACH certification. Regardless of the DRG at issue, any suggestion that a patient who stays in a LTACH facility for longer than the qualifying twenty-five day length of stay (that has been established as a requirement for LTACH 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 LTACH PPS than it is for IPPS, or any other PPS system. CMS's 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 LTACH providers' great detriment, all of an LTACH provider's risk under the SSO payment system is enhanced while the Medicare program's risk is drastically reduced.

Promise 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 LTACH provider, or a company such as Promise that operates a number of LTACH facilities, is virtually guaranteed under the SSO proposal to be paid less than cost. In this manner, CMS's proposed rule on SSO reimbursement violates the intent underlying the establishment of LTACHs as a separate class of hospitals and Congress's and CMS's own understanding of the legislative intent behind the IPPS, LTACH PPS, and all other PPS systems.

In its August 2002 final rulemaking establishing LTACH 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 [LTACHs] 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's new proposal runs contrary to the structure of LTACH PPS. The LTACH 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 LTACHs to furnish the most efficient care possible to each patient are included, and LTACHs 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 LTACH 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 the LTACH PPS. Radically decreasing payment levels for the vast majority of patients whose length of stay is under the average is completely contrary to the fundamental structure and presumptions of LTACH PPS.

Moreover, there is no incentive for LTACHs to admit large numbers of cases that may fall below the average length of stay. Even if LTACHs do not apply stringent screening criteria to limit all admissions only to LTACH appropriate patients, and even if SSO cases could be identified at the time of admission and selected (presumably to maximize reimbursement), LTACHs still would have no incentive to admit such SSO cases. If an LTACH admits short-stay patients in any numbers, this lowers the LTACH's average length of stay and puts the LTACH at risk of losing its certification status in the very next reporting period due to a failure to maintain the required average length of stay of greater than twenty-five days. CMS's concerns that LTACHs are purposefully selecting SS0 cases are unsupported and vastly overblown.

In an LTACH 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 twenty to forty day range, there is likely to be far more variation in the length of stay, in terms of number of days admitted, and far less certainty at admission, 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. Promise is uncertain to what extent and why CMS does not recognize this fundamental distinction between the IPPS and the LTACH PPS and how application of the law of averages plays out in either type of facility.

Even more fundamentally, by introducing a proposal to pay SSO cases at IPPS rates, CMS facially violates the mandate of Congress in establishing LTACHs 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 LTACH as "a hospital which has an average inpatient length of stay . . . of greater than twenty-five days." Whereas this provision includes the term "average," it must be concluded that Congress fully understood and intended that a significant portion of LTACH patients would experience lengths of stay well below the twenty-five day certification standard. Otherwise, Congress would have included a ***minimum*** length of stay of twenty-five 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 LTACHs inappropriately and proposing to pay these cases under IPPS methodology, CMS is, frankly, substituting its own will in place of the Congress's. To make matters worse, CMS is now proposing to pay SSO cases in LTACHs 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's proposal, the only outlier payment for which an LTACH PPS SSO case can qualify is an LTACH PPS high cost outlier payment that would, by definition, occur in the same admission as a short-stay outlier most infrequently.

4. **Contrary to established PPS principles, the Proposed Rule for SSOs assures that no case will be paid at greater than its cost** and many will be paid less than cost – guaranteeing a system that pays less than the cost of care

In the Proposed Rule, when discussing the background to its reimbursement proposals and decisions in the past, CMS describes the appropriateness of the IPPS in part by reminding the reader that although in some cases providers will be reimbursed at less than their costs, in other cases those providers will be reimbursed in excess of their costs. CMS proceeds to conclude that the system, as thus fashioned, on average is fair.

By virtue of the drastic reductions to SSO case reimbursement, however, the Proposed Rule ignores this principle and virtually guarantees that no case will ever be paid at greater than its cost and that virtually every short-term outlier that stays in an LTACH for longer than one week will be reimbursed at significantly less than cost. Such a system represents a marked departure from PPS principles.

CMS proposes to limit payment for SSO cases to IPPS payment rates. This would cause LTACHs to be significantly underpaid, based on CMS's own estimates of SSO case numbers, perhaps for upwards of 35% of the patients served by LTACHs. Payment under the Proposed Rule for SSO cases to LTACHs operated by some LTACH provider operators would likely fall to only 57% of the providers' actual costs incurred in caring for those SSO patients.[2] CMS's proposal fails to acknowledge and account for the fact that those patients who are indeed most likely to need LTACH care, the sickest patients with the most medically complex cases, are often initially admitted to a general acute care hospital prior to any determination of their appropriateness for LTACH care. The best available data simply does not support CMS's belief expressed in the Proposed Rule that the IPPS hospital payment rate is sufficient to cover the cost for carrying for this most medically complex of patient groups. Based on data collected from CMS's own data base, as presented by ALTHA in its March 10, 2006, comments, the payment rate to an LTACH for a patient who is ventilator dependent assumes that the patient will stay in the LTACH about thirty-four days, on average. An LTACH could provide excellent care and discharge such a patient after only twenty-six days. Under CMS's new proposal, the LTACH would be forced to accept the IPPS hospital payment rate for this patient, a rate formulated on the basis that the patient was expected to be hospitalized for

[2] Estimate in comments submitted by Acute Long Term Hospital Association ("ALTHA") in response to Proposed Rule, March 10, 2006.

only about eight days. Attempting to pay an LTACH for twenty-six days of care based on the payment rate for eight days in an IPPS hospital is grossly unfair and mathematically disproportionate.

CMS also assumes that LTACHs can easily change their behavior so as to accommodate this draconian reduction in payment for SSO cases. CMS suggests that LTACHs simply will be forced to refuse to admit SSO patients. This is plainly unrealistic. It is not normally possible to predict prior to admission whether a particular patient will become a SSO in an LTACH. Although LTACH 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 LTACH, there is no crystal ball or obvious predictive marker, at least of which Promise is aware, that can determine whether a particular LTACH DRG 475 patient will stay eighteen days, twenty-three days, twenty-six days, twenty-nine days, thirty-two days, forty days, or three months. To condition so drastic a payment reduction formula on an LTACH's ability to discern the future before it happens, and to do so regularly, sometimes three weeks before an event happens, is patently unrealistic and exceedingly unfair.

Data presented to CMS by ALTHA, 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 non-SSO cases. Indeed, the percentage of SSO cases falling into each of the ten most common LTC-DRGs is remarkably comparable to the percentages of non-SSO cases falling into such LTC-DRGs.

CMS's proposed draconian shift in LTACH payment policy, coming so quickly on the heels of the initial LTACH PPS rate setting process, the initial budget neutrality adjustment and the few subsequent annual updates, raises the question of the continued appropriateness of the LTACH payment rates overall. When CMS established the various features of LTACH PPS and then applied annual updates since that time, CMS's calculations necessarily contemplated the existence of an SSO patient population comparable to, if not greater than, the percentage (37% as of 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 LTACH PPS, necessarily would have taken into account the amounts of those payments for SSO cases under the existing SSO formula. These previously anticipated SSO case reductions also necessarily impacted other elements of LTACH 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 LTACH PPS, without a corresponding increase in payment rates for non-SSO cases, calls into clear question the ongoing fairness and viability of the overall LTACH PPS payment system.

B. Proposal To Not Update The RY 2007 Federal Rate

1. CMS's position is inconsistent with Congress's intent and CMS's policy.

CMS proposes that the LTACH 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 LTACH case mix index ("CMI") and margins before and after implementation of LTACH PPS and the latest available LTACH cost reports, which purportedly show that LTACH Medicare margins were over

8% for FY 2003 and 11% for FY 2004. CMS's 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* December 8, 2005, MedPAC Meeting Transcript, page 165. Of note, Congress has not agreed to, 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 LTACH services. In addition, Promise notes that the CMS proposal not to 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.

2. **The basis of the proposal not to update the RY 2007 federal rate is fundamentally flawed.**

The case mix index ("CMI") is defined by CMS as an LTACH'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 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 changes in LTACHs' 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 LTACH claims data from the first year of implementation of LTACH PPS and compared it to FY 2001 claims data generated prior to the initiation of LTACH PPS. 3M determined that the average CMI increase from FY 2001 to FY 2003 was 2.75%. CMS assumes from this data that the same 2.75% "real" CMI increase remained constant during the next year or two of LTACH 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 LTACH documentation and changes in coding practices. Several errors are apparent.

First, CMS did not take into account the fact that many LTACHs did not begin to transition to LTACH PPS until some time during FY 2004, the second fiscal year of the LTACH PPS transition. Thus, CMS's assumptions that more than half of the 6.75% rise in CMI between FY 2003 and FY 2004 is attributable to better LTACH coding and documentation is unsupported, at least with respect to some portion of the LTACH facilities at issue. The fact that CMS did not look at the latest case mix data from FY 2004 (or later), when all LTACHs in operation at the time LTACH PPS went into effect had already begun the transition to LTACH 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 LTACH's payment (for those LTACHs that chose to transition to LTACH PPS over five years), it is far less likely that LTACHs were "aggressively coding" LTACH 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-LTACH PPS average CMI increase and the post-LTACH PPS average CMI increase. These false assumptions cannot form the basis for meaningful policy.

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 LTACH 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 LTACH, 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 the particular LTACH at issue admitted hospital level patients, to conclude that the entire industry should not get a market basket update on such sparse and unreliable data is totally unsupported. For its part, Promise has experienced less than a one of every 1000 admissions denied on QIO review with respect to the medical necessity of its services provided to LTACH patients. That Promise facilities should be denied their 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 unsupportable as policy.

Third, CMS has utterly failed to consider the re-weighting of LTC-DRG rates earlier this fiscal year. CMS does not in any manner discuss in the Proposed Rule the impact that the re-weighting of LTC-DRG rates earlier this year had on LTACHs' CMI since the implementation of the LTACH 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 LTACHs) for the same reason that CMS now proposes to apply no market basket update for RY 2007 that is, according to CMS calculations because PPS reimbursements to LTACHs were higher than LTACH costs in 2004. 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 LTACH 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 LTACH FY 2004 MedPAR data, and we believe that the increase of relatively lower charge cases being assigned to LTC-DRGs was higher relative weights that we observed in the FY 2004 LTACH claims data . . . accurately represents current LTACH 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 LTACHs 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 LTACH 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 LTACH PPS, LTACH coding practices resulted in patients being assigned to DRGs with reimbursements that are higher than the LTACH'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 eliminating now 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, LTACHs will be unfairly penalized a second time for the same reason.

Fourth, there is absolutely no basis for CMS not to use its highly touted, new RPL Market Basket Index in the first year of its existence. In the Proposed Rule, CMS discusses on page after page the high degree of precision and 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) for 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.

C. The Proposed Rule Runs Contrary To MedPAC's Recommendation To Conduct Studies To Determine Appropriate Clinical Criteria For LTACH Admissions

CMS has commissioned a study by the Research Triangle Institute ("RTI") to analyze the LTACH provider category and determine the feasibility of implementing MedPAC's recommendations (in the June 2004 report to Congress) for creating new LTACH facility and patient criteria. The criteria would be designed to assure that patients admitted to LTACHs were medically complex and have a good chance of improvement. The RTI study has received broad support from the LTACH industry, from CMS, from Congress, and from most reimbursement analysts on both the provider and payor side. Yet, with the results of the study and RTI's recommendations apparently only less than a year away, CMS now acts largely to ignore MedPAC's and its own commission's

study and has instead proposed arbitrary and draconian short stay outlier methodology changes in place of a consistent, popular and meaningful set of reforms designed to assure that appropriate patients are admitted to LTACHs.

Promise does not agree fully with CMS's characterization of RTI's mandate. For example, Promise rejects the idea that the proper measure of outcomes is cost per case, which appears to be at least one of the measures in the RTI study methodology. Cost per case is meaningless without controlling for patient acuity. Promise therefore urges CMS to assure that a proper study of patient acuity is included in any discussion of cost per case as a measure of outcomes.

With that caveat, Promise agrees with MedPAC's recommendation that certification criteria for LTACHs be developed. Promise also fully supports CMS's decision to evaluate the LTACH provider community's practices and quality review programs. Promise believes that all of its LTACHs should meet specific criteria designed to assure they can provide the resource - intensive and specialized services LTACH patients need. Promise looks forward to continued discussions with regard to building an appropriate set of criteria on which to judge LTACH capabilities and performance and by which to assure that patients are appropriately admitted to LTACH facilities throughout the country.

In light of these upcoming results, Promise urges CMS not to implement the short-sighted SSO policy it has proposed, and to make appropriate changes to LTACH policy only later, once appropriate data have been reviewed, analyzed, and modeled. The proposed short stay outlier payment policy will not achieve any of the objectives of the MedPAC recommendations regarding quality of care, appropriateness of admission, and certification of providers. Rather, it will deny care needlessly, place unrealistic burdens on LTACH providers, and foist far too much risk on the backs of care givers who will be forced to respond to short-sighted policy with unavoidable, yet potentially ill-advised admission decisions.

D. Freestanding LTACHs And The 25% Patient Referral Criterion For Hospitals Within Hospitals

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

CMS now seeks to set its sights on the perceived unexplained growth of freestanding LTACHs. CMS appears to believe that if a freestanding LTACH admits a high percentage of patients from a single short-term acute care hospital, that fact alone suggests that the two providers

are likely to be somehow defrauding the system and are therefore worthy of some type of investigation or payments restriction. CMS fails to consider, however, that small sized, specialized LTACHs, 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 LTACH. This is not some type of collusion; it is simply the arithmetic of the community in which the LTACH and the large tertiary care provider are located. Promise continues to believe that any reasonable concerns held by CMS about the appropriateness of admissions to LTACHs can best be addressed by reasonable clinical admission criteria.

Promise agrees that every effort should be made to assure that patients are not inappropriately transferred to any LTACH (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 LTACHs. It is our view that the "proliferation" of LTACHS is an appropriate response to the medical needs of the ever increasing and aging senior segment of our population. They are the most vulnerable to multisystem, medically complex maladies – exactly the vision of care that we, MedPac, and CMS believe should be treated in our LTACH.

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

Second, the mere fact that many large hospitals are the primary sources of patients for specific LTACHs should not come as any surprise. Generally, patients and their families want to stay within a certain community or neighborhood for their care. To the extent an LTACH is providing high quality services, why should a local physician or hospital placement office not seek admission where necessary to that particular LTACH within the same community?

It should also come as no surprise to CMS that any particular LTACH 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 or consolidated; in some parts of the country there are only large hospitals within any given community. An LTACH located in such a community or part of a larger city is likely to get a majority of its patients from those large hospitals. There is absolutely nothing inappropriate about such referrals, provided the patients who are being admitted through such referral source are appropriate candidates for LTACH admission, which Promise certainly believes they are in its own case. As stated above, Promise facilities have experienced less than a 1% denial rate based on CMS contracted QIO review.

In addition, it is somewhat absurd to think that a freestanding LTACH 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 LTACHs is supported by the policy reasons discussed in the Proposed Rule.[3]

Furthermore, until the transition period for the HIH 25% rule is completed for all LTACH HIHs (between October 1, 2007, and September 30, 2008), CMS will not be in a position to know whether the HIH payment adjustment is achieving the stated policy goal without limiting access to care. For this reason as well, it would be unwise to extend the HIH restriction to freestanding facilities.

Promise also believes that certification criteria remain the far more rational and clinically sound approach, consistent with the MedPAC recommendation that the certification criteria for the Medicare LTACH provider category be strengthened to reduce unnecessary growth in a number of LTACHs who are not treating medically complex patients with multiple co-morbidities. Promise continues to support, in lieu of unsupported non-clinically based criteria, the establishment of criteria reflecting MedPAC's recommendations focusing on patient characteristics for LTACHs, the structure and operation of LTACHs, and ensuring that LTACH patients exhibit an appropriate need for LTACH level care. Promise urges CMS to accept and carefully consider input from the provider community in developing any such criteria and to avoid rushing into implementing ill-advised non-clinical criteria without extensive study of its objectives and the best way of achieving them.

E. CMS Should Follow Its Own Established Process For Reviewing The Appropriateness Of Admissions

Based on the thrust of the proposed rule, CMS has ignored its own established process for reviewing the appropriateness of admissions: QIO review. CMS has started over the past few years to fund freestanding quality improvement organizations that review medical records to determine the appropriateness of admission and continued stay decisions. In the past year, Promise Healthcare has had less than one case for every 1,000 patients that has been declined by the QIO for appropriateness of admission or continued stay. Promise believes that its experience is similar to the LTACH industry in general, and does not understand why CMS does not place more credence in these data and use them to formulate its adjustments of LTACH policy and reimbursement objectives.

If CMS does not believe that the QIOs it has selected and contracted are accomplishing CMS's objective in their reviews, then CMS should work with the QIOs to change their focus. To the extent the QIOs are doing what CMS has asked, however, it makes no sense for CMS to dismiss or ignore QIO findings . From what Promise understands from its own and other LTACH operators' experiences, QIO review data do not support CMS's assumption that SSO cases were inappropriately admitted to LTACHs. To the contrary, QIOs have overwhelmingly found that LTACH patients have appropriately been admitted and treated in LTACHs across the country.

Promise certainly does not have any issue with its facilities' admissions being "placed under the microscope" by CMS's contracted QIOs, but Promise does take issue with the undeniable perception that CMS is not taking the QIO results seriously. There is no point to ongoing, extensive

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[3] Neither do we mean to imply that we believe the 25% rule is appropriate even for HIHs.

case review if the results of that review do not become strong considerations in future clinical and payments policy review.

F. 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 LTACH payments in the Proposed Rule based on certain identified and unidentified data sources. These data do not support the alteration of payment obligations under LTACH 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 LTACHs. 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, Promise seeks the revision of erroneous data relied upon and disseminated by the Secretary of HHA and the Administrator of CMS in the formulation and publication of the Long-Term Care Hospital Prospective Payment System ("LTACH 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.*

Promise believes that CMS has not thoroughly reviewed the data it cites as support for the changes to LTACH payments in the Proposed Rule that are discussed in these comments, above, nor does Promise 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 LTACH 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 "utility involves the usefulness of the information to its intended users" and that utility 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 LTACHs fails to meet the required standard. CMS has relied on FY 2003 data for various purposes associated with LTACH PPS even though many of the affected providers, including some Promise providers experienced their first full year on LTACH PPS in FY 2004. Therefore, CMS's 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 LTACH PPS year was in FY 2004. This clearly impacts CMS's 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 LTACH reviews in formulating its assumption that many LTACH 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 LTACH PPS DRG code (DRG 475). In short, CMS failed to use reliable data sources, and used extremely limited samples

and data sets 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's analyses are often not presented. The data and other supporting information is not transparent; thus, Promise 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.

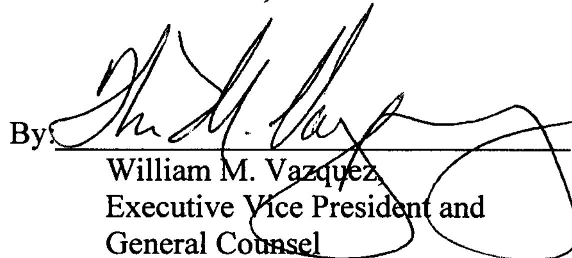
G. CMS failed to Accurately Complete the Regulatory Impact Statement

Promise 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 LTACH PPS is unsubstantiated. Without a doubt, the aggregate effect of the currently proposed LTACH PPS payment reduction, the recent reweighting of the LTC-DRGs, and the amended guidelines regarding DRG 475 would be significant.

Promise believes that, however well intentioned CMS's 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 LTACH PPS fiscal year's data, why and to what degree such far-reaching changes and massive reductions to reimbursement are indicated.

Respectfully Submitted,

Promise Healthcare, Inc.



By: ______________________
William M. Vazquez
Executive Vice President and
General Counsel

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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:

The Baylor Specialty Hospital submits these comments on proposed rules published on January 27, 2006 at 71 *Fed. Reg.* 4648 et seq. This rulemaking seeks to make significant changes to the admission practices of long-term care hospitals (LTCHs) as well as payment policies. The Baylor Specialty Hospital was established on July 1, 1989 and is located at 3504 Swiss Avenue, Dallas, Texas. It serves a significant percentage of Medicare patients residing in the North Texas area. CMS' proposed short-stay outlier rule and zero update proposals would drastically reduce payments to Baylor Specialty Hospital in fiscal year 2007 by approximately 15 percent, forcing Baylor Specialty Hospital to operate at a loss when treating Medicare patients. The Baylor Specialty Hospital urges CMS to not adopt the proposed short-stay outlier rule and zero update proposal because the continued operation of Baylor Specialty Hospital and the patients it serves will be placed in jeopardy if they are adopted.

Short-Stay Outlier Proposal

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

Through the SSO policy CMS has assumed that SSO patients in LTCHs are similar to short-term acute hospital patients assigned to the same DRGs. To the contrary SSO patients have a relative case-mix index of 2.0592 which is 110% greater than the relative case-mix index of 0.98734 assigned to patients with the same DRGs in short-term acute hospitals. These SSO patients therefore have a higher medical acuity and use moremedical resources than are reflected in short-term hospital payments. The higher acuity of LTCH SSO cases is further demonstrated by a higher death rate of 19.61% for

SSO cases in LTCHs vs. 4.81%. The average length of stay of SSO cases in LTCHs is 72% greater (12.7 days vs. 7.4 days) than the average stay in short-term acute care hospitals.[1]

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

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

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

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

Further, CMS ignores MedPAC's recommendation contained in its June 2004 report to Congress that CMS designate Quality Improvement Organizations (QIOs) to review the medical necessity of LTCH patient admissions. There is a comprehensive statutory and regulatory scheme which vests QIOs with authority to review the medical

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

necessity of hospital services provided to Medicare beneficiaries. QIOs, which are composed of licensed doctors of medicine, determine, among other things, whether inpatient hospital services furnished to Medicare beneficiaries are consistent with generally accepted standards of medical care, or could be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type and the medical necessity, reasonableness and appropriateness of hospital admissions and discharges. See Sections 1154(a)(1) and (3)(C) and of the Social Security Act and 42 C.F.R. §476.71(a).

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

No Fiscal Year 2007 Update

CMS' proposal to provide a zero fiscal year 2007 update, combined with the proposed SSO proposal will force Baylor Specialty 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 Baylor Specialty Hospital in jeopardy. At a minimum, it will reduce Baylor Specialty Hospital's ability to finance medical care and services provided to indigent populations and defray the cost of bad debts. Ultimately, it will threaten Baylor Specialty Hospital's ability to survive.

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

Sincerely,

Gerry Brueckner, President

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Joel T. Allison, F.A.C.H.E.
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March 16, 2006

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

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

Dear Dr. McClellan,

On behalf of Baylor Health Care System (BHCS), I offer the following comments on the proposed rules published Jan. 27 at 71 *Fed. Reg.* 4648 et seq. Baylor Health Care System, as well as other Texas hospitals, relies on long-term care hospitals as a critical part of the state's health care delivery system. BHCS patients and acute-care hospitals, as well as LTCHs, are harmed by this proposal. The rules force changes in the admission practices of LTCHs and implement punitive payment policies. LTCHs treat severely medically complex patients and offer specialized services not appropriately provided in other settings.

The proposed short-stay outlier rule and zero-update proposals reduce payments to LTCHs in fiscal year 2007 to a level that they could not continue to care for Medicare patients. Baylor urges CMS to consider the implication of denying the services of LTCHs to Medicare patients. Denying access to LTCH services could have very serious consequences to patients and taxpayers as these patients are left to other long-term care alternatives with little hope of fully independent living.

The CMS short-stay outlier and market update proposal continues the trend of degrading payment system integrity to reach budgetary and policy objectives. I respectfully urge CMS to reconsider these proposals.

Sincerely,

Joel Allison, President and CEO
Baylor Health Care System

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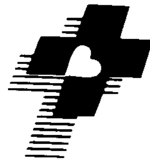


Youville Hospital
& Rehabilitation Center

Via Federal Express

March 17, 2006

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

Dear Dr. McClellan:

Youville Hospital & Rehabilitation Hospital, Inc., provider number 222000, welcomes the opportunity to comment on the Prospective Payment System (PPS) for Long-Term Care Hospitals (LTCHs): RY 2007: Proposed Annual Payment Rate Updates and Policy Changes, and Clarification, Proposed Rule, as published on January 27, 2006 at 71 Federal Register 4727 *et seq.*

Overview

Before we begin our comments, we call to CMS' attention the comments proposed by the National Association of Long Term Hospitals (NALTH), in its letter dated March 13, 2006, and the report by the Lewin Group commissioned by NALTH and included as Appendix A to NALTH's letter. We incorporate some of Lewin's findings in our comments. We have also included Youville-specific statistics to the extent that we have completed internal analyses which apply the proposed rule changes to Youville's Medicare discharges.

1575 Cambridge Street, Cambridge, Massachusetts 02138-4398 617 876-4344 FAX: 617 547-5501

To begin, we acknowledge that CMS must strive to be a prudent purchaser of services while ensuring that beneficiaries have access to a stable, secure network of high-quality providers along the full continuum of care. However, the substantial payment reductions in its proposed rule may cause CMS to fall short of its responsibility to beneficiaries. The reductions proposed to current payments average 11 percent nationwide and 13 percent for New England. These reductions approach 15 percent nationwide and 17 percent for New England when the proposed elimination of the annual inflation update is also considered. According to Lewin, these payment reductions will cause not-for-profit LTCHs to suffer a negative 8.8 percent average margin. Youville's internal analyses are largely consistent with Lewin's – Youville's reductions will be 16 percent, as Medicare payments will fall by $6.9 million annually from ***current*** levels and by $7.6 million when the zero inflation update is taken into account. Youville's FY2007 operating margin is projected at negative 8-9 percent.

Youville simply cannot sustain this level of operating losses. Across the industry, margins this low will undoubtedly threaten the viability of many other LTCHs as well. The impact of these payment reductions on beneficiaries' access to care would be unprecedented. This impact will not only affect LTCHs but their "upstream" acute care referral hospitals as well. LTCHs are an integral component of the continuum of care in the greater Boston metropolitan area. The proposed rule creates significant financial disincentives *(regardless of medical appropriateness)* for LTCHs to admit patients who may become short stay outliers (SSOs), thus extending their stays in acute care hospitals that are not as well-equipped to address these patients' multi-disciplinary needs. The acute care hospitals in Youville's market area frequently experience emergency room "diversions" due to capacity constraints. We believe that the proposed rule would exacerbate this situation by disrupting the transition of patients from the acute care hospitals' intensive care units (ICU) to Youville and other LTCHs. Patients will occupy ICU beds longer, which will ultimately reduce the acute care hospitals' ability to accept patients into their emergency rooms.

PROPOSED CHANGES TO THE 2007 LTCH PPS PAYMENT RATES

I. 0 Percent Inflation Update

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

- Payment increases resulting from case mix "upcoding" entirely offset the 3.6 percent increase in the Rehabilitation, Psychiatric, Long Term Care (RPL) market basket, and
- "current payments are more than adequate to account for price increases in the services furnished by LTCHs during the 2007 LTCH PPS rate year".

Case mix "Upcoding"

- ***"Real" case mix growth from 2003 to 2004 is equal to the average annualized pre-PPS case mix growth from 2001 to 2003***. We question CMS' assumption that "real" case mix growth under the LTCH PPS is equal to case mix growth pre-PPS. Certainly at Youville, the average intensity of Medicare inpatients has, in fact, increased significantly from pre-PPS levels. During the past few years, Youville has successfully increased admissions to its high-acuity programs (e.g. ventilator weaning, wound care, chronic obstructive pulmonary disease, etc.) in anticipation of future LTCH criteria which will prescribe LTCH admission eligibility. Youville has made significant investments in new ventilators; expanded telemetry and monitoring systems; nurse education and training; and physician services. Also, Youville has appointed physicians from the Massachusetts General Hospital's Oncology Services and the Brigham & Women's Hospital's Division of Pulmonary Medicine to serve as medical directors of these clinical programs at Youville. All of these efforts have been undertaken to ensure that Youville is capable of providing the highest level of quality of care for these resource-intensive patients.

The increase in Youville's case mix is reflective of a more medically-complex patient population, and Youville depends upon its higher case mix to generate appropriate reimbursements to pay for its investments in human and capital resources.

- ***Payment growth (17%) from 2002 to 2003 exceeded cost growth (8%).*** Specifically for Youville, our average Medicare reimbursement per case increased by approximately 12 percent from 2002 to 2003, significantly below the LTCH-industry average. During the same period, our average cost per patient day increased by approximately 9 percent. Youville's experience demonstrates a much tighter correlation between revenues and expenses than the broader LTCH industry.
- ***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 directly through Quality Improvement Organizations (QIOs) or some other measure of medical necessity, not indirectly through the payment system. As for Youville, our QIO is MassPRO. During our most recent fiscal year 2005, MassPRO randomly selected 25 medical records for its review. Youville has received ***NO*** admission denials.

Current Payment Adequacy

- ***12.0 percent Medicare margin in 2004***. We concur that Medicare payments must not reward inefficient providers. However, we ask CMS to consider that efficient providers need a modest margin, roughly 4 to 5 percent, to provide for capital investments that ensure high quality of care. We concur that a 12 percent margin is excessive. However, MedPAC projects that the industry average margin will drop to 7.8 percent in 2006 (chapter 4C, MedPAC March 2006 Report to Congress, page 218), while the Lewin study projects 2006 margins at 9.2 percent. Furthermore, Youville's Medicare margin in 2004 was approximately 8 percent in 2004 and declined modestly to 7 percent in 2005. While Youville's margins are modestly above the requirement for capital investments, we clearly cannot absorb the unprecedented proposed reimbursement cuts of over 16 percent. Finally, if we

were to consider both Medicare and Medicaid, Youville's margin would drop substantially.

- ***Tremendous growth in LTCHs.*** The growth in LTCHs during the past several years may be indicative of a generous payment system. However, this growth may also indicate that LTCHs' role in the continuum of care is evolving nationwide. Regardless, CMS's response to this growth must be measured and targeted so as not to disrupt the continuum of care, particularly in locales like eastern Massachusetts, where LTCHs are long-established and, consequently, few alternative sites of care exist.

Furthermore, as Youville has increased the medical complexity of its patients, we find ourselves increasing in competition with acute care hospitals with respect to staffing. The market basket update is needed to remain competitive with acute care hospitals for the recruitment and retention of scarce, highly-skilled clinical staff. The lack of a market update would put Youville at a significant competitive disadvantage in our marketplace.

II. Short Stay Outlier Cases

CMS has been seeking answers to the following questions: for which patients are LTCHs the appropriate site of care? and, what are the common characteristics of those patients? We believe these to be proper questions for a prudent purchaser of care to ask. Furthermore, we believe that CMS must arrive at *clinically-based* answers to its questions in order to ensure the highest regard for beneficiaries' care. To CMS' credit, it is seeking such a clinical answer through the Research Triangle Institute (RTI) study.

Therefore, we were surprised to find in its proposed rule that CMS has suddenly determined that LTCHs are not admitting the appropriate patients simply because 37 percent of LTCH cases have lengths of stay shorter than $5/6^{th}$ of the average. And we were very dismayed to see that CMS' proposed policy imposes an across-the-board payment penalty, rather than the implementation of clinical criteria (being developed by RTI and others, including NALTH), to direct LTCH admission decisions for nearly 40 percent of all

LTCH patients. The severity of the SSO payment reduction can only be described as catastrophic. According to Lewin, the margins on SSO cases will drop to a negative 81 percent under the proposed rule. Youville's internal analyses estimate SSO margins of approximately negative 52 percent.

Even more troubling is the fact that SSO reimbursements are currently providing the margins that keep overall PPS payments in balance, by offsetting losses on high-cost outliers in particular. As CMS has cited in virtually all PPS rulemaking, this balancing of payments is the most fundamental tenet of any PPS – an average payment specifically set to overpay some cases and 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, but actually reverses it by creating industry-wide negative margins.

In the proposed rule, CMS makes a number of statements indicating that care for many SSOs should either remain at the acute care hospital or be provided in another 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.
- 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,

- 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 days, is 72 percent higher than that of acute hospitals (7.4 days). Youville's experience is close to the industry average, with an ALOS for SSOs of 12.5 days.
- 86 percent of SSOs have lengths of stay exceeding the mean IPPS LOS. For Youville, this statistic equals 85 percent.
- The ALOS for SSOs within the 3 highest volume LTCH-DRGs reveals lengths 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 rule have a case mix index 109 percent greater than acute care patients assigned to the same DRGs.

- We believe that taking the IPPS payment system, which is based on the set of illnesses, treatment patterns and cost structure of short-term acute hospital providers and simply applying that system to the different illnesses, treatment patterns and cost structure of LTCHs, is totally inappropriate. We believe that NALTH makes a convincing case that imparting IPPS payments on the LTCH PPS is directly contrary to the LTCH PPS enabling statute.
- CMS states in its proposed rule that it does not want to pay for patient care twice – once in the acute hospital, and then again in the LTCH. We find this statement particularly troubling given that CMS has recently made this exact same argument in several IPPS proposed rules in support of its expanded post-acute transfer policy, which will reduce payments to acute care hospitals by $900 million in 2006.

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 $5/6^{th}$ ALOS threshold;
- 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 concurrently with the resolution of the patient's medical issues. We note the study by the Barlow Respiratory Hospital Research Center (cited in NALTH's 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 emphasized. We believe that CMS would have made definitive statements if irrefutable data had been available to support its assertions. We believe that the magnitude of the proposed reimbursement changes is simply not justified given the lack of supporting data.

Finally, we express our strong objection to the fact that CMS, through its proposed SSO payment policy, is overriding the medical necessity decisions that Congress has delegated to the QIOs. We support NALTH's comment:

> "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. We have participated in numerous discussions with other LTCHs, our acute care referral hospitals, our statewide hospital association, NALTH and our Board of Directors and employees. Youville is committed to a balanced approach in such recommendations, striving to achieve what we believe to be the best balance between the concerns raised by CMS, the needs of our patients and Youville's need for a reasonable margin when providing care to Medicare beneficiaries. We offer the following recommendations:

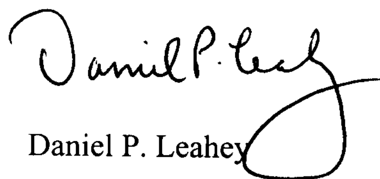
1. Intensify and expand QIO review. CMS' over-arching concern throughout the preamble to its proposed rule regards the appropriateness of care in LTCHs. We cannot overstate our firm conviction that Youville, and the broader LTCH industry, provide essential care to Medicare beneficiaries. This care is unique in its ability to deliver an efficient and effective multi-disciplinary approach to the medically-complex patients they serve. Furthermore, we cannot overstate our conviction that appropriateness of care must be determined clinically, and not proscribed by the payment system. QIOs already have the Congressional mandate and necessary infrastructure in place to expand and accelerate their efforts. We would anticipate that some results from this intensified and expanded review would be available to inform proposed rulemaking for 2008.
2. Abandon the proposed implementation of the IPPS payment system for LTCH SSOs. Maintain the current 3-tiered payment methodology for SSOs, with the following modifications:
    a. "Very" short stays, those SSOs with a length of stay shorter than 10-20 percent of the LTCH DRG geometric ALOS, will be paid under the current 3-tier system with the cost option reduced to 100 percent (down from 120 percent) of the cost.

   b. All SSOs that do not qualify as "very" short stays will be paid under the current 3-tier system with the cost option reduced to 110 percent (down from 120 percent) of the cost.
   c. Patients who die in the LTCH and patients who exhaust their Medicare benefit days would be exempt from the "very" short stay payment policy and would be paid under item b, above.

3. Enact a 0 percent market update ***only if*** no modifications are made to the SSO payment formulas. This recommendation is consistent with MedPAC's March 2006 Report to Congress in which MedPAC recommended a 0 percent market update given its projected LTCH margins and no change in LTCH payment policies. If CMS were to implement reductions to SSO payments in its LTCH PPS final rule, then the full 3.6 percent RPL market update should be provided.
4. Consideration of a two-year moratorium on new LTCHs. 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.)

We thank you for this opportunity to comment. Please contact me 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 LTCHs and the LTCH PPS.

Yours truly,



Daniel P. Leahey
President & CEO

MAR 17 2006

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NDHA
North Dakota Healthcare Association

Vision
The North Dakota Healthcare Association will take an active leadership role in major healthcare issues.

Mission
The North Dakota Healthcare Association exists to advance the health status of persons served by the membership.

March 15, 2005

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

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

Dear Dr. McClellan:

The North Dakota Healthcare Association (NDHA), on behalf of our long-term care hospitals, 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 NDHA – most notably the proposal to omit the 3.6 percent market basket update and proposed changes to the short-stay outlier (SSO) policy. The alarming net impact of this proposal – negative 14.7 percent – is excessive and would severely and inappropriately threaten patient access to LTCH care.

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

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

Annual market basket updates are intended to compensate for year-to-year inflationary increases in the cost of delivering health care services. An annual inflationary update to the LTCH PPS, and all prospective payment systems, is essential to maintaining an accurate payment system that helps providers safely care for patients. As such, it is wholly inappropriate to exclude a market basket update for LTCHs in RY 2007, as recommended by the proposed rule. The RY 2007 market basket calculation of 3.6 percent under both the RPL market basket method and the current methodology validates the real inflation costs LTCHs will face next year, which must not be overlooked in the final rule. In addition, to omit the market basket update to offset coding changes is a misuse of the market basket.

Proposed Adjustment for SSO Cases

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

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

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

CMS proposes to significantly modify the LTCH SSO policy, which is intended by CMS

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

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

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

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

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

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

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

<u>LTCHs care for a distinct population.</u> CMS states that by treating SSO cases LTCHs may be "functioning like an acute care hospital." However, in taking this position CMS has overlooked essential differences between the LTCH case mix, including SSO cases, and the case mix treated by hospitals under the inpatient PPS. For instance, The Lewin

Group has compared common LTCH and inpatient PPS DRGs and found that the case-mix index (CMI) for LTCH SSO cases is more than double the CMI for general acute hospitals.

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

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

NDHA Recommendations

The NDHA recognizes that recent LTCH growth is appropriate for close oversight by Congress, CMS and others. However, **efforts to slow LTCH growth should be based on balanced and thoughtful policymaking that ensures access for patients who are medically appropriate for LTCH care.** At the facility level, adding criteria to the current 25-day ALOS requirement would produce a major improvement in focusing LTCH care on specific populations. At the patient level, expanding medical necessity review by clinical experts would achieve the goals of prudently using Medicare resources and preserving the rights of beneficiaries to access necessary care. **These balanced approaches, discussed in greater detail below, should be utilized rather than the**

blunt policies such as the current cap on host-hospital referrals for co-located LTCHs and the proposed SSO policy changes. Both of these policies fail to focus on the clinical characteristics and needs of patients and instead rely on overly broad, non-clinical proxies (LOS and referral source) to determine whether an LTCH admission is appropriate.

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

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

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

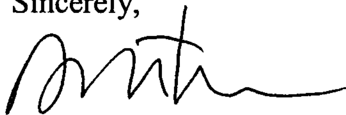
CMS should authorize and fund expanded QIO review, which would provide assurance to Congress and the Secretary that Medicare funds are being utilized prudently while preserving the access rights of Medicare beneficiaries. Expanded QIO review would be an effective complement to new, more specific LTCH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

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

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

The NDHA appreciates the opportunity to comment on this proposed rule. To discuss our comments and concerns, please contact Chester Huseby, CEO at the SCCI Hospital, Fargo, North Dakota (701) 241-9099.

Sincerely,



Arnold R. Thomas
President

cc: Sen. Conrad
Sen. Dorgan
Rep. Pomeroy

*** RECEIVED ***
Mar 10,2006 11:37:40 WS# 06
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CORRESPONDENCE
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From: "Write your representative" <writerep@heoc-www6.house.gov>
Date: 2/27/2006 2:01:49 PM
To: IN01IMA@mail.house.gov
Subject: WriteRep Responses

DATE: February 27, 2006 1:40 PM
NAME: Ms. Susan Brenner
ADDR1: 9135 Cleveland St.
ADDR2: Apt. 202
ADDR3:
CITY: Merrillville
STATE: Indiana
ZIP: 46410
PHONE:
EMAIL:
msg:
Dear Honorable Peter J. Visclosky:

I am a resident of Lake County, (Merrillville, IN) and would like to ask for your help with an important issue regarding the hospital where I work. I am a Unit Secretary at a local "long term acute care" (LTAC) hospital (Regency Hospital). There are only 350 LTAC hospitals in the country, and they represent only 1% of Medicare spending. However, LTAC hospitals are a vital subset of healthcare facilities which help the sickest patients who need, on average, 25 days of inpatient care.

I am concerned about a proposed CMS rule that, if implemented, would cut LTAC hospital payments nearly 15 percent and would not even cover the operating costs of caring for this unique, medically complex patient population. The CMS proposed rule would seriously destablize this small, but vital, health care sector, and risk patient access to the unique care that it provides.

It is my belief that this rule goes too far, too fast, and, further, comes on the heels of another major rule change last year that, in effect, substitutes the judgment of CMS, for the treating physician, as to the best setting for care.

Please join me in uring CMS totake a step back on this ill-advised proposed role, and to take a major leap forward to establish, clear, transparent, clinically-based criteria to certify an LTAC hsopital, as well as fair and reasonable payment rates and policies.

Sincerely,

Susan Brenner

*** RECEIVED ***
Mar 10,2006 11:37:40 WS# 06
OFFICE OF THE SECRETARY
CORRESPONDENCE
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From: "Write your representative" <writerep@heoc-www6.house.gov>
Date: 2/27/2006 9:32:04 PM
To: IN01IMA@mail.house.gov
Subject: WriteRep Responses

DATE: February 27, 2006 8:50 PM
NAME: Karen Meinert
ADDR1: 408 W Rolling Meadows Drive
ADDR2:
ADDR3:
CITY: Valparaiso
STATE: Indiana
ZIP: 46385-9093
PHONE: 219-464-0725
EMAIL: kmeintk39@comcast.net
msg:
I am a Clinical Liason at Regency LTAC "long term acute care" hospital of Northwest Indiana and Porter County. There are only 350 LTAC hospitals in the country and they represent only 1% of Medicare spending. Our facilities help the sickest patients who need on average, 25 days of inpatient care versus short stay hospitals whose average lenght of stay is only 6 days. Clearly, these hospitals treat substantially different patient populations, and our health care system needs to properly serve the health care needs of all of the citizens you represent.

I am concerned about the proposed CMS rule that if implemented, would cut LTAC hospital payments by 15% and may not even cover operating costs caring for the unique complex patient populations that we serve. The CMS proposed rule would severly destabilize this small, but vital health care sector and risk patient access to the unique care that it provides.

I think that if this rule goes to far, to fast and comes on the heels of another major rule change last year our patient populations will be suffering at the hands of the CMS.

Please urge the CMS to take a step back on this ill-advised proposed role, and to take a major leap forward to establish clear, clinically based criteria to certify an LTAC hospital as well as fair and reasonable payment rates and policies.

Sincerely yours,
Karen Meinert CRT
Clinical Liason
Regency Hospital of Northwest Indiana and Porter County

SCCI Hospital
Specialized Complex Care
4777 East Outer Drive • Detroit, MI 48234 • 313/369-5800 • Fax 313/369-5876 • www.sccihospitals.com

March 16, 2006

VIA OVERNIGHT DELIVERY

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: CMS 1485P, "Other proposed policy changes for 2007 LTCH PPS Rate Year, Proposed Adjustment for Specific Cases, Adjustments for SSO Cases"

Dear Administrator:

I am writing to you today from SCCI Hospital in Detroit, MI concerning the proposed annual payment rate updates, policy changes, and clarifications under the prospective payment system for long-term care hospitals (LTCHs) for FY 2007. I have detailed the particulars below relating to the fundamental issues which are brutal and illogical.

The letter will focus on the "Adjustment for SSO Cases and Proposed Changes to the Method for Determining the Payment Amount for SSO Cases" with added commentary on the other policy changes. My attention in this letter will focus primarily on the use of Short Term Acute Hospitals (STAC) IPPS system for Short Term Outliers (SSOs) of LTCHs, or as CMS refers to it, a payment system comparable to STAC IPPS.

When congress originally excluded LTCHs from IPPS in 1983 (and CMS originally issued regulations for LTCHs) they were excluded because of the vastly different types of patients treated and resources consumed. Specifically, CMS stated that this exclusion from IPPS was because the use of IPPS for LTCH "would be inaccurate and unfair" and was "not designed to account for types of treatment" found in LTCHs (Aug. 31, 2002 FR, Vol.67, No.169, p.55957). CMS itself in 2002 said that applying IPPS to LTCHs could "systematically underpay" LTCHs "if the same DRG system were applied to them." (August 31, 2002 Fed. Reg.)

With the proposed rule, CMS is now completely reversing position and proposing that LTCHs be paid IPPS rates for 37% of the patients treated in LTCHs (SSOs). Clearly when 37% of patients are paid a rate of less than 43% of the actual costs to provide care, hospitals

will suffer severely, and ultimately so will patients, families, nurses, physicians, and the community at large. *This proposal will endanger the most vulnerable and fragile patients in our society and likely the industry as a whole.* CMS is proposing to pay LTCH IPPS rates for SSOs based on faulty assumptions, insufficient data, and a fundamental lack of understanding of the valuable care provided by LTCHs across the country.

This proposal is based upon numerous erroneous assumptions such as:

1. **LTCHs are taking "premature and inappropriate" patients that have not received their full care from the STAC.**

In fact, admissions to LTCH from STAC hospitals actually had over double the average length of stay in the STAC hospital than the STAC average for those same DRGs. Specifically, patients admitted to an LTCH from a STAC hospital averaged more than a 13-day stay in the STAC before admission to LTCH vs. the geometric mean of those same DRGs in STAC of 6 days. Therefore, LTCH patients had twice as long a hospitalization as normal in the STAC to receive their normal amount of care before admission, a direct contrast to the "premature and inappropriate" accusation. In addition, since the 2004 Medpar data that was used in this analysis, CMS has added an additional 200 DRGs under the Transfer Regulations that will further discourage STACs from making premature discharges to LTCH. The impact of the additional transfer DRGs was not even considered in this proposed rule. Even though these SSO patients have had an extensive stay in STAC before admission to LTCH they are still severely ill. Under the new AP-DRG system the percentage of severely ill patients in LTCH is double that of the STAC, 66%LTCH vs. 33%STAC (% of APDRG Severity of Illness (SOI) categories 3&4)

2. **LTCH SSOs are predictable and hospitals are admitting them because of an "inappropriate financial incentive" and are admitting patients "with lengths of stay more typical of an acute care hospital."**

In fact, average length of stay for SSOs in LTCHs is 13.1 days vs. geometric mean length of stay (GMLOS) in STAC for the same DRGs of 6.1 days. Therefore, the LTCH patients have a length of stay averaging over twice the length of stay in STAC for the same DRG. The patients being admitted to LTCH are not the same and should not be treated the same as the general population of the STAC.

A significant portion of LTCH SSOs are patients that unfortunately, and unexpectedly, die. For the SCCI Hospitals, 25% of our SSOs are attributable to deaths. The faulty assumption has been that LTCHs can predict deaths and are taking these SSOs intentionally. *This could not be further from the truth.* Because of the severity of illness of LTCH patients and the number of co-morbidities, the predictability of length of stay and death is much less accurate than in STAC. In fact, even in STAC there are a large number of early deaths when

compared to GMLOS. While clinicians may exercise sound judgment and have "gut feels", there are no accurate tools available for predicting mortality in an LTCH setting. The need for LTCHs to exceed the 25 day LOS also undercuts the argument that LTCHs intentionally take short stay deaths. LTCHs sometimes unexpectedly have a 25-day problem. Almost always it is because of unexpected deaths.

The patients are severely ill with 66% of SSOs in LTCHs in AP-DRG severity of illness categories (SOIs) of 3(major) or 4(extreme) compared to STAC average of 33%. LTCH patients average at least one more co-morbidity than the STAC average and patients are two years older than even the average age of outliers in STACs.

Additionally, just under 11% of SCCI Hospitals SSOs were already outliers in STAC before admission to LTCH, certainly not early discharges from a STAC facility. More than 7% of SSOs had greater than a 25-day length of stay, hardly a typical stay at a STAC facility.

3. **37% of patients in SSOs is "inappropriately high."**

CMS utilized FY 2004 Medpar data to develop the payment policies included in the proposed rule, which only reflected the first year of transition into PPS for LTCHs, and a substantial number of LTCHs had not even fully transitioned to PPS in FY 2004. With one year of data, CMS concludes that SSOs in LTCHs have dropped from 48.4% to some 37% one year post transition to PPS. A drop from over 48% to 37% would hardly suggest that the payment policies in place were not having the desired effect. Recent data released by Lewin shows that STACs have 40% of their cases shorter than 5/6 of their GMLOS, so is this inappropriately high? Of course not, it is the nature of the bell curve and the PPS system that some patients fall below and some fall above the mean. A cutoff was chosen (5/6) related to the cost methodology (120% of cost) and the desire not to create a cliff. Then the original % was noted (48.4%), then the drop was noted (37%), and then a new formula was created (IPPS for SSOs) *based on no identifiable data or appropriate methodology*. Even though the lengths of stay compared to STAC are more than double, the severity of illness in LTCH is also double that of STAC. Many cases are already outliers in STAC before admission to LTCH, many SSOs are unpredictable deaths and a sizable number have more than a 25-day length of stay in LTCH, yet CMS proposes to pay LTCHs via a system developed for a completely different patient population.

Assessment of IPPS for LTCH

This payment methodology also will create a "cliff" (just what CMS did not want to do) just before the 5/6 point because it is based on STAC IPPS which has a very short GMLOS. The average length of stay in STAC is 5.3 days versus LTCH of over 25 days. The proposed payment methodology would generally pay a full IPPS DRG payment at 6 days and no additional payment until the 5/6 point or at least 22 days. That is 16 days without additional

reimbursement. The vast majority of these patients do not hit outlier status in LTCHs (81% of SSOs will be paid under proposed IPPS) and the closer they get to the 5/6 the lower the payment per day is until the difference (between full pay and IPPS pay) the day before the full LTCH DRG is the largest "cliff". This is directly contrary to your own opinion (71 FR 4686) where you state supportively that the cost methodology "which results in a gradual increase in payment as the length of stay increases without producing a payment "cliff" at any one point, provides a reasonable payment option under the SSO policy." The IPPS methodology when applied to SSOs creates exactly this cliff the longer the patient stays past the GMLOS for STAC and the closer they get to 5/6. We have already established that the average length of stay for SSOs is over double STAC GMLOS. The interaction of the lower of cost or IPPS will result in the perverse financial incentive of maximizing SSO reimbursement at the geometric method length of stay for STAC or around 6 days. **Given your theory of "inappropriate financial incentives" you should expect average SSO length of stay to be around 6 days in LTCHs based on this perverse economic incentive.**

The result will be limiting access to care for any type of diagnosis/treatment that might have a long stay but has a substantial portion of that type of patient having a 17-18 day length of stay, such as ventilator (DRG 475). Too many of these SSOs will cause a hospital to go under even though the majority might meet the GMLOS and those that missed only missed by a few days. *The most fragile, older, most unpredictable, and most vulnerable patients would be the most at risk.* SSO patients are older, sicker, more intense, more unpredictable, more likely to die and thus are the types of patients LTCHs are supposed to admit and care for. However, a significant percentage have the unfortunate problem of unexpected death or other unexpected outcomes.

Even though a cursory analysis of the data would prove the above points, CMS is proposing paying LTCHs on average 43% of costs for SSOs. In fact, the longer the stay the less the pay per day. The reason we admit them now is not because of our "inappropriate financial incentive" or desire to get "premature and inappropriate" admissions but because these patients need our specialized care, are no longer appropriate for STAC, and we believe that they would benefit clinically from our services. Although our SSO patients are sicker and length of stay is twice as long as STAC, we would be paid less per day the closer the patient gets to the LTCH GMLOS.

Alternatives and Conclusion

CMS should implement a method as proposed by MEDPAC designed to tighten clinical and facility criteria to address the concerns about clinical appropriateness. SCCI and the industry as a whole are concerned about this as well. We would welcome the chance to work together with CMS on this issue. CMS should release and use the RTI analysis to develop proposals rather than initiating this vast change without this study. If CMS is concerned about very short stays it should use a variation on the original proposed

regulation on LTCH PPS which is to have a separate, lower payment for up to 7 day stays. That is, pay a lower percentage of cost for these very short stays as is done for high cost outliers. CMS should use the cost methodology for all SSOs even though we don't find it desirable. It is, however, much better and more appropriate for SSOs, relates to length of stay, and does not create a cliff as STAC IPPS does. QIOs should be held to their responsibility of enforcing clinical criteria and monitoring LTCHs to ensure appropriateness. We believe the combination of the above alternatives would slow the growth of the industry, meet many of CMS's concerns, and ensure the appropriateness of patients in LTCHs as well.

In closing, CMS should work with the industry, not seek to destroy it.

Sincerely,

Kim M. Knight
Chief Executive Officer

March 16, 2006

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

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

Dear Dr. McClellan:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

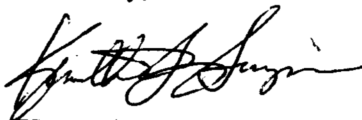
Further, the MedPac recommendation of March 2006 only recommends one change and that is to give no market basket increase in our 2007 PPS rates. The MedPac analysis also shows a 9.0% margin for LTACH's in 2004 and a projected 7.8% margin for 2006. Our facility has analyzed the case weight changes made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

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

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

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

Sincerely,



Kenneth L. Simpson
Administrator

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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.* – CMS-1485-P

Dear Dr. McClellan:

The Hospital for Extended Recovery, affiliated with Sentara Healthcare, located in Hampton Roads, Virginia, would be significantly negatively impacted by the above mentioned proposed regulation. I write to you today to express my concern about this regulation. Unless modified, this regulation, which provides for a zero update factor and severe penalties to Long Term Acute Care Hospitals (LTCHs) for admitting Short Stay Outlier (SSO) patients, would hurt hospitals in our state and the inpatients.

The Hospital for Extended Recovery has been serving patients in our region for the past five years. In FY 2005, 33.6% of Hospital for Extended Recovery patients fell into the SSO category. Some of these patients do much better than anticipated and are able to return to their homes much sooner and others experience unforeseen complications and leave the facility earlier than anticipated for a higher level of care or due to death. The unpredictability of these circumstances makes the payment penalties so severe.

The patients treated by the Hospital for Extended Recovery are some of the most severely ill and medically complex patients in our area. The hospital serves as a vital component to Virginia's health care system. The Hospital has had significant success in being able to return patients to their pre-hospitalization living environments. Indeed, well over 50% of the patients are able to return to their homes.

CMS' proposed short-stay outlier rule and zero update proposal would drastically reduce payments to LTCHs in fiscal year 2007 by approximately 15 percent forcing LTCHs to operate at a loss when treating Medicare patients. I urge CMS not to adopt the proposed short-stay outlier rule and zero update proposal because the continued operation of the Hospital for Extended Recovery in the Commonwealth of Virginia will be threatened if the regulations are adopted. Of even greater concern, the patients served by the Hospital will be placed in jeopardy.

Sincerely,

Robert C. "Bobby" Scott
Member of Congress

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