Because the referenced comment number does not pertain to the subject matter for CMS-1529-P, it is not included in the electronic public comments for this regulatory document.

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CMS-1529-P-5

Because the referenced comment number does not pertain to the subject matter for CMS-1529-P, it is not included in the electronic public comments for this regulatory document.

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Submitter : Dr. Timothy McCurry **Date:** 02/19/2007

Organization : Resurrection Family Medicine Residency

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

See Attachment

CMS-1529-P-9-Attach-1.PDF

Comments DGME Changes – Timothy McCurry, MD

With the proposed changes in calculating teaching time, you have targeted Family Medicine for economic failure or will change how medical education is actually done in our field.

For simplicity, calculations assume that a resident only does **one** learning activity in any one month or time period. This may be true for internal medicine or other specialties, but in Family Medicine it is not unusual and in fact encouraged to have many longitudinal experiences along with episodic or rotation attendance/responsibilities. This is effective use of teaching and utilizing the resident's learning time wisely at various sites. By requirements Family Medicine residents spend every week in their hospital teaching sites seeing clinic patients, so it is impossible for them to get the full 3 hour teaching time per week.

The new Family Medicine ACGME guidelines in fact allow for the program to have responsibilities up to 5 half days that are away from their assigned rotation in a week. This basically is their hospital clinic time and hospital patient care activities. In the other 5 half days, they can attend their rotation which could include non-hospital teaching sites. THIS IS THEN A HALF-TIME rotation, not a full time rotation and should not be considered at full cost.

Many programs have some months that a resident does two-half days in one physician's non-hospital teaching office and 2 half days in different non-hospital teaching site. Since there is no proration of this time, I have to pay potentially twice as much for this type of experience which would cost less if they just went to one office.

We have tried to document non-patient teaching time and have been unsuccessful since no one but the program director is interested. The resident doesn't care; the non-hospital teaching physician is would be too busy documenting instead of teaching and doesn't want to be bothered.

I firmly believe you need to use the formula you have created, but allow for proration within the week or change the 3 in the formula based on the year group, to a 1 for third year residents, a 2 for second year residents and keep the 3 for 1st year residents as these would more accurately describe how much time a resident spends in a non-hospital teaching situation.

Submitter : Dr. michael horseman **Date:** 02/20/2007

Organization : Christus Spohn Hospital Corpus Christi-Memorial

Category : Pharmacist

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

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

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

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

CMS-1529-P-11 **Prospective Payment System for Long-Term Care Hospitals RY2008: Proposed Annual Payment Rate Updates, Policy Changes, and Hospital Djirect and Indirect Graduate Medical Education Payments**

Submitter : Roxanna Gapstur **Date & Time:** 02/24/2007

Organization : University of Minnesota

Category : Nurse

Issue Areas/Comments

Background

Background

Long-term care hospitals (LTCHs) are defined as hospitals which admit clientele with a length of stay longer than 25 days. These patients are generally in need of long-term rehabilitation or treatment related to either a catastrophic injury or chronic illness, including chronic dementia or psychiatric problems. The care is provided by a multidisciplinary health care team consisting of physical medicine and rehabilitation physicians, geriatricians, clinical nurse specialists, dieticians, professional nurses, licensed practical nurses, physical therapists, speech therapists, occupational therapists, and nursing assistants. Under the LTCH prospective payment system (PPS), a medicare payment is made at a predetermined rate for each specific discharge. The payment varies by the LTCH-DRG (diagnostic-related group) that is assigned. Cases are classified based on the following six items: 1) principal diagnosis, 2) up to eight additional diagnoses, 3) up to six procedures performed, 4) age, 5) sex, and 6) discharge status of the patient. Cases are organized into about 538 DRGs, most of which are determined by organ system of the body.

Impact

Impact

This proposal is well thought out and will stabilize the LTCH payment system by bringing estimated payments very near to actual payment rates. With collection of data in the past two years, the fluctuation rates of coding inaccuracies are minimal. This points to an adequate capture rate with the current software and LTCH coding accuracy. These particular rules will begin in 2008 giving all LTCHs an opportunity to incorporate the new rules into their current coding practices prior to that time. Current coding practitioners at LTCHs will review the revised weighting system carefully in order to determine further comments needed to refine the proposed rules. Stabilization of budgets for LTCHs is an important consideration as well as additional revenue for newer technologies impacting patient outcomes. Without weighting systems and additional adjustment factors, it is impossible to provide care to this complex patient population. Provision of these additional adjustments will compensate LTCHs for their comprehensive multidisciplinary care programs thereby gaining additional benefits for the patients care for in these facilities.

LTC-DRG Classifications and Relative Weights

LTC-DRG Classifications and Relative Weights

In order to encourage efficiency and appropriate level of services for each individual, the DRGs under the LTCH-PPS

system are weighted. This weighting assures that the DRG represents the amount of resources an average individual with that diagnosis would need. Those LTCH DRGs with a weight of 2 would need on average about twice the resources as those given a weighting of 1.

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

Under this new proposal, CMS proposes to update the LTCH-DRG system in a budget neutral manner to allow for changes in hospital resource use, including new technology. Providing these updates in a budget neutral manner allows for less fluctuation in payments to long-term care hospitals under the PPS system. The current weighting system would continue to reflect the LTCH resources used for that patient. In order to accomplish this in a budget neutral manner, CMS proposed the use of a budget neutral adjustment factor which would ensure the payments under PPS would approximate the estimated yearly payments to any particular LTCH.

Submitter : Mr. Edward Coyle **Date:** 03/01/2007

Organization : Mercy Health System

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attached File

CMS-1529-P-12-Attach-1.DOC

#12

Mercy
Health System

One West Elm Street,
Conshohocken, PA 19428

March 1, 2007

Leslie V. Norwalk, Esq.
Administrator
Center for Medicare & Medicaid Services
Department of Health and Human Services
CMS-1529-P
P.O. Box 8015
Baltimore, MD 21244-8015

RE: CMS-1529-P, Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008, 72 Federal Register 4776

Dear Ms. Norwalk:

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule on prospective payment system for long-term care hospitals rate year 2008, published February 1, 2007 in the Federal Register. I am the Director of Revenue and Reimbursement for Mercy Health System of Southeastern Pennsylvania.

PROPOSED CHANGES TO LTCH PPS PAYMENT RATES FOR THE 2008 LTCH PPS RATE YEAR – OTHER PROPOSED POLICY CHANGES FOR THE 2008 LTCH PPS RATE YEAR:

Section V.B. Proposed Expansion of Special Payment Provisions for LTCH Hospitals Within Hospitals (HwHs) and LTCH Satellites: Proposed Expansion of the 25 Percent Rule to Certain Situations Not Currently Covered Under Existing § 412.534 (page 4809): CMS is proposing that for any discharges in excess of 25% admitted from a non-co-located hospital (that had not already reached outlier status) would be subject to a payment adjustment. The burden on the freestanding LTCH would be onerous. The discharging acute care hospital would not even have their UB-92 complete yet at the time of the LTCH admission to be able to inform the receiving LTCH if the case was in outlier status. There would be no way at time of admission for the receiving LTCH to be able to calculate if the patient was in outlier status at the referring hospital, without knowing the total charges incurred at the source hospital, the DRG coded at the source hospital, the source hospital's cost-to-charge ratio, and the source hospital's Medicare base rate in the PRICER system (which includes the operating and capital IME% and operating and capital DSH%), all components of the outlier calculation. The focus of the acute care hospital and the LTCH should be on the patient, and getting the patient to the most appropriate level of care determined by the

physician. The focus should not be managing the intake of the LTCH to the degree of no more patients from X hospital, because we have exceeded some arbitrary limit set by the Secretary of Health and Human Services as a payment disincentive. Because the payment adjustment for those cases that exceed the 25% threshold are so dramatic, the fiduciary duty to the LTCH will require that we strive to implement some type of policy to limit our exposure to this adjustment. Since identifying which patients are in outlier status prior to admission is practically impossible for the LTCH, it will be forced to use a flat 25% for each referring hospital, thereby limiting access for Medicare beneficiaries to the level of care deemed most appropriate by their physician.

I also take issue with the limited exception that CMS has come up with to address geographical issues related to the 25% rule. The MSA dominant hospital exception would not be feasible in a large urban area such as Philadelphia, PA. There are 47 hospitals in our MSA, 37964, per the CMS 2008 Wage Index PUF file, which includes several large academic medical centers. It is highly unlikely that any hospital in this MSA would exceed the 25% threshold to be recognized as an MSA dominant hospital. The reality of a large urban setting such as Philadelphia is that referrals between facilities are greatly influenced by geographic proximity within the MSA.

I realize that CMS is proposing this rule in response to their perception that co-located hospitals/LTCHs currently operating under this rule are moving the LTCH off-campus to get around the limitations imposed by the 25% rule. Therefore I suggest that CMS, instead of expanding the 25% rule, move toward adopting the MedPac recommended patient and facility criteria for LTCHs, as a way of defining clinically appropriate admissions to an LTCH. CMS should stop trying to manage utilization through arbitrarily conceived financial disincentives, and focus more on what is clinically appropriate.

LTC–DRG CLASSIFICATIONS AND RELATIVE WEIGHTS

Section III.D.2. Proposed Budget Neutrality (BN) Requirement for the Annual LTC–DRG Update (page 4784): I agree with CMS' proposal to include a budget neutral (BN) requirement for the annual update to the LTC–DRGs.

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

Section IV.C.2. Proposed Update to the Standard Federal Rate for the 2008 LTCH PPS Rate Year (Page 4791): CMS is proposing to update the standard rate by 0.71%, in spite of the fact that the RY 2007 update factor was 0.0% with an RPL market basket of 3.4% and the RY 2008 RPL market basket is projected to be 3.2%. CMS explains the 0.71% update as the market basket of 3.2% minus apparent CMI change of 2.49%. The apparent CMI of 2.49% being the 'observed' CMI change of 3.49% (FY 2004 compared to FY 2005) minus the 'real' CMI change of 1.0 (from RAND study '87 to '88). CMS defines apparent CMI as the increase due to coding changes. However, in the DRG recalibration section of this proposed rule (page 4785), CMS states that FY 2006 represented 'real' CMI vs. 'apparent' CMI,

> "...based on the most recent available LTCH claims data, which is discussed in section IV.C. of this preamble, also supports our belief that observed CMI increase is primarily due to changes in real CMI (that is, increased patient severity) rather than apparent CMI (that is, changes in coding practices). Specifically, this CMI analysis indicates that changes in LTCH coding practices,
> which resulted in fluctuations in the LTC–DRG relative weights in the past, appear to be stabilizing as LTCHs have become more familiar with a DRG-based system...."

CMS should not be reducing the market basket increase by an 'apparent' CMI amount to account for coding changes, when they state in another section of the rule that industry has caught on to coding and CMS is observing 'real' CMI, stabilized and reflecting changes in resources.

On page 4792 CMS stated that they are soliciting comments on other data sources that could be used to determine a proxy for real LTCH PPS case-mix change other than the 1.0 to 1.4 percent per year case-mix parameters based on the RAND study. I believe that the best proxy for the 'real' CMI is the observed CMI, adjusted for any providers with atypical CMI changes (positive and negative) being removed.

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

Section IV.D.3.c. Proposed Adjustment for High-Cost Outliers (HCOs) - Establishment of the Proposed Fixed-Loss Amount (page 4796): When calculating the fixed-loss threshold, CMS should not be taking into account the 1.3% decrease due to FY 2007 LTCH-DRG relative weights, as mentioned on page 4799, since the FY 2008 LTCH-DRG weights are currently proposed to be calculated in a budget neutral manner. The other factors in the projected decrease in the LTCH payments include the short stay outlier (SSO) proposed change and the phase-in of the wage index adjustment. CMS gives the fixed-loss threshold as calculated without the SSO change of $18,207, which is still a 22.30% increase from the current $14,887. That is too large of an increase to be accounted for by the 0.5% payment decrease due to the phase-in of the wage index, which is more than offset by the 0.71% adjusted market basket increase.

CMS notes that they are currently developing additional instructions on administration of the outlier reconciliation process, similar to IPPS. In these additional instructions CMS should specifically spell out in this final rule, as well as for IPPS, how it interprets the 10-percentage point change, with specific examples, so that changes in the Administrator (we are on our third since the outlier reconciliation became a rule) will not change the interpretation of the rule. Under Scully, the CMS verbal guidance quoted in the Reimbursement Advisor (newsletter, September 2003) was 10% not 10-points, so that a change from an RCC of 0.50 to 0.44 exceeded a 10% change from the 0.50 RCC, qualifying for reconciliation. More recent guidance under McClellan gave full 10-point examples, a change from 0.50 to 0.40 would require reconciliation. The confusion with this example is that it also exceeds the 10% interpretation. CMS should publish an example that clarifies, for example, a change from 0.50 to 0.42, well over 10%, but not quite 10-points. Does that change qualify for reconciliation or not?

OTHER PROPOSED POLICY CHANGES FOR THE 2008 LTCH PPS RATE YEAR

Section V.A.2. Additional Discussion of the SSO Payment Formula (page 4804): CMS is proposing that the short stay outlier for when the length of stay is less than or equal to an IPPS-comparable threshold (very short stay outlier), which is equal to or less than the IPPS DRG GMLOS plus one standard deviation. In the RY 2007 proposed rule, CMS proposed the fourth "lesser-of" option for the SSO as the IPPS payment. That proposal was revised into the current blend methodology of the IPPS per-diem and the LTCH per-diem. This blend methodology should be enough to adjust the payment for the very short stay outlier to an IPPS equivalent payment. The claims data that RTI and CMS used to come to their conclusions supporting the current proposed rule was prior to implementation of RY 2007 blend. Payment changes as a result of the RY 2007 SSO additional "lesser-of" option should be given a chance to work through the claims systems and be properly and fairly included in the evaluation before coming to any conclusion that more payment adjustments are required.

The RTI report in several places and tables identifies DRG 475 (now DRGs 565 and 566) as the most common LTCH admission. Theoretically it may sound good to say that an LTCH LOS within one standard deviation of the IPPS LOS is more like an IPPS case then an LTCH case, but the numbers for this leading LTCH DRG tell a different story. The LTCH GMLOS for DRG 565 is 34.7 days, the SSO 5/6th threshold is 28.9 days, the IPPS + one standard deviation is 23.3 days, and the IPPS GMLOS is 13.4 days. So if your LOS is 6 days (17.29%) less than the GMLOS you are in the SSO calculation. Under the proposed very short stay outlier rule, another 5 days less and you are eligible for the IPPS-comparable payment amount. At this LOS, 23.3 days, you are still 10 days, or 173.88%, higher than the 13.4 day IPPS GMLOS, but could still be paid the IPPS rate. At this LOS the current SSO rule with the blend would seem to be the more logical payment option, as the 23 day LOS at the mid-point between the 34 day LTCH GMLOS and the 13 day IPPS GMLOS, but that option is now replaced by the IPPS-comparable payment. The large standard deviation observed in DRG 565, could be due to, as CMS states in the CCR discussion (page 4797) "...since there are less than 400 LTCHs, which are unevenly geographically distributed throughout the United States..." the fact that acute care facilities not located near an LTCH are forced to keep these patients for the full course of treatment, whether clinically appropriate or not. This uneven geographic distribution skews the data used to calculate the standard deviation, which is why for DRG 565, with an IPPS GMLOS of 13.4 days, the standard deviation is 9.9 days, or 73.88% of the IPPS GMLOS, almost double its length. In a House of Representatives bill introduced January 18, 2007 by Rep. Conrad of ND, he mentioned that North Dakota has two LTCHs, two LTCHs in the entire state of North Dakota. How could any acute care hospital LOS data not be skewed when they only have two LTCHs to refer their patients in the entire state? CMS is attempting to limit the growth in the number of LTCHs through payment restrictions such as this, but the example of North Dakota with only two LTCHs highlights the fact that there are geographic areas in need of more LTCHs. My preferred outcome is for CMS to abandon this proposed IPPS-comparable (very short stay outlier) adjustment, as I believe the RY 2007 blended option already accounts for the very short stay patient. However, if CMS is determined to make such an adjustment, some of the standard deviations are too large as compared to their IPPS GMLOS, CMS should make the threshold the lesser of the actual standard deviation or 25% of the IPPS GMLOS or some other reasonable proxy.

The technical correction on page 4808, would add the term "covered" immediately before the phrase "length of stay" in the initial definition of a SSO case. DRG-based payments are a per case reimbursement methodology. The intent behind the SSO is to penalize LTCHs for treating patients in the LTCH that would be better served in an acute care setting. To use only the covered days for a Medicare exhausted patient would pay as a SSO a patient who might actually remain in the LTCH for the entire GMLOS or more. CMS should not penalize the LTCH for accepting a patient whose Medicare benefit exhausts during a stay that otherwise would meet or exceed the GMLOS for the DRG. The exhaust patient would not qualify for high-cost outliers for charges beyond the exhaust date, but they should still be entitled to the full LTCH-DRG payment if they had Part A eligibility upon admission. Exhausting Part A benefits during the stay should not be used to determine if the SSO payment rules come into play.

PROPOSED CHANGES TO LTCH PPS PAYMENT RATES FOR THE 2008 LTCH PPS RATE YEAR

Section IV.D.6. One-Time Prospective Adjustment to the Standard Federal Rate (page 4802): The Secretary maintains that he has broad authority to make a one-time prospective payment adjustment to the LTCH rates, and that at the end of the five-year transition period CMS will have a sufficient amount of data to determine if / what adjustment would be necessary. After the RY 2007 0% base rate increase and

the RY 2008 0.71% proposed increase, we have already had a significant adjustment, 3.4% and 3.2% market basket adjustments forgone. CMS should either do away with one-time adjustment or at least credit the industry with the impact of those forgone market baskets, as those adjustments will not be fully accounted for in multiple-year data used to arrive at one-time adjustment amount.

Also, CMS should take into account when determining any one-time adjustment the cases that were paid based on the SSO rule after the RY 2007 and proposed RY 2008 adjustments. Those cases may not have received the full benefit of the base rate, and it would be inequitable to lower the rate going forward using payment data for cases paid at the full rate in years prior to these lower payments going into effect. The first years under LTCH PPS did not have these adjustments, and therefore would be overstating net reimbursement as compared to the current payment methodology. The combination of no market basket adjustment in RY 2007, 0.71% in RY 2008, and the SSO blended option of RY 2007 and the proposed SSO IPPS-comparable option of RY 2008 combine to more than make up for the one-time adjustment the Secretary maintains he is still entitled to implement.

PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION

Section XII.B.5. Residents Training in Nonhospital Settings - Implementation of a 90 Percent Cost Threshold (page 4822): CMS has proposed to allow a proxy for the physician teaching costs, 3 hours per week at a national average salary per a national physician salary survey. First of all, I want to thank CMS for offering the additional clarity and new alternatives for determining teaching physician costs in a non-hospital setting. You are soliciting comments on whether to use the mean or median amounts per the survey, I propose that the salary amounts that should be used as a proxy or average should be the current RCE amounts. The salaries listed by specialty in the proposed rule are far in excess of the RCE amounts that the Secretary has repeatedly defended as not requiring periodic updates, as they are considered reasonable. One example, Surgery, RCE amount = $180,000, current proposed rule salary information Table 7 = $331,970. If the RCE amount is supposed to represent reasonable cost, then to pay 84.43% more would imply there was a prudent buyer issue, and CMS would disallow this excess cost on the cost report if actually paid to the teaching physician. CMS should not be offering a proxy that is so far over their own reasonable cost RCE amounts. CMS relies on the Social Security Act § 1861(v)(1)(A) which allows the Secretary to establish limits as *reasonable* based on estimates of costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs under this title [subchapter XVIII of chapter 7 of Title 42] to support the RCE limits as reasonable. The proxy for recognizing GME/IME teaching time should not be greater.

Thank you for your review and consideration of these comments. If you have any questions, please feel free to call me at (610) 567-5563.

Very Truly Yours,

Edward J. Coyle
Director, Revenue & Reimbursement

Submitter : Mr. **Date:** 03/02/2007

Organization : Mr.

Category : Hospital

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

Guidance for calculation of education cost in non-hospital setting not available when per resident amount established. As such, the allowable cost was not included resulting in per resident amount being understated. Hospitals should be allowed option to recaleulate their per resident amount to include this allowable training cost to insure appropriate payment by Medicare.

Because the referenced comment number does not pertain to the subject matter for CMS-1529-P, it is not included in the electronic public comments for this regulatory document.

CMS-1529-P-15

Because the referenced comment number does not pertain to the subject matter for CMS-1529-P, it is not included in the electronic public comments for this regulatory document.

Because the referenced comment number does not pertain to the subject matter for CMS-1529-P, it is not included in the electronic public comments for this regulatory document.

Submitter : Mr. Robert Williams **Date:** 03/15/2007

Organization : Mercy Special Care Hospital

Category : Long-term Care

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1529-P-17-Attach-1.DOC

#17

Mercy Special Care Hospital
128 W. Washington Street
Nanticoke, PA 18634
570-735-5000

March 15, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1529-P
P.O. Box 8015
Baltimore, Maryland 21244-8015

Re: Comments on Medicare Program; 2008 Proposed Update Rule Published at 72 Federal Register 4776 *et seq*.

Dear Ms. Norwalk:

Mercy Special Care Hospital submits these comments on proposed rules published on February 1, 2007 at 72 *Fed. Reg.* 4776 et seq. This rulemaking seeks to make significant changes to the admission practices of long-term care hospitals (LTCHs) as well as payment policies.

Mercy Special Care Hospital was established as a hospital in 1908 and as a LTCH in 1993 and is located at 128 W. Washington Street, Nanticoke, PA 18634. It serves a significant percentage of Medicare patients residing in Northeastern Pennsylvania. CMS' proposed expansion of the 25% rule to freestanding and grandfathered hospitals, and its "consideration" of a policy to expand the short stay outlier ("SSO") payment policy to allow "extremely" SSO cases to be paid comparable to IPPS cases, both are unfair and unsupported by facts, and contrary to the clinical and financial data available. The two proposals would drastically reduce payments to Mercy Special Care Hospital in fiscal year 2008 by approximately $3 million, forcing Mercy Special Care Hospital to operate at a loss when treating Medicare patients. Mercy Special Care Hospital urges CMS to not adopt the proposed expansion of the 25% rule and to reject its consideration of the extremely SSO policy because the continued operation of Mercy Special Care Hospital and the patients it serves will be placed in jeopardy if they are adopted.

In the preamble to the update rule CMS repeatedly justifies both of its proposals by making the generalized, unsupported, and incorrect statements that in the situations the proposals are intended to address the LTCH is behaving like a ACH, or that the LTCH is acting like a step-down unit for a ACH, or that the patient presumably was discharged by the ACH to the LTCH during the same episode of care and the LTCH is not providing complete treatment. CMS points to the statutory difference between LTCHs and ACHs that was intended to pay LTCHs based upon "the different resource use" of LTCHs as compared to ACHs. In fact, LTCHs do provide different services to

patients, and patients in LTCHS they do utilize different resources than ACHs, making it inappropriate to pay LTCH discharges under the IPPS, and CMS has presented no data to the contrary to support its proposals other than presumptions and beliefs. CMS' own contractor, RTI, noted in the Executive Summary to its report that "[u]nderstanding whether LTCH hospitals are substituting for services already paid to IPPS hospitals or whether LTCHs are providing specialized services is not well understood." 72 Fed. Reg. 4885.

As described in greater detail in the comments submitted by NALTH, physicians at ACHs use their expertise and experience to discharge certain patients to LTCHs because the specialized care they can receive at the LTCH is very different than the services provided at an ACH, and such care, and the timing of such care, clearly are in the best interests of the patient's medical care. In general, ACHs are "diagnosis focused" and provide critical care to acutely ill patients by focusing on a single clinical dimension, whereas the LTCH is designed to provide the complete array of team-based services that can focus on the recovery of the whole patient. LTCHs often help patients recover all functions (both cognitive and physical) and return to the community. ACHs simply are not designed to provide these services, and there is no current incentive for them to expend the significant resources to try to replicate those specialized services that already exist in LTCHs. The physicians at the ACH also make the medical determination of when the patient is appropriate to be transferred from the ACH to a LTCH based upon the patient's condition, medical needs, and availability of appropriate services. It makes little sense for a patient to remain at an ACH instead of being transferred to a LTCH, and thus delay (or eliminate entirely) the commencement of needed specialty services, purely for payment system reasons.

Despite CMS's generalized statements to the contrary, Lewin has demonstrated that SSO patients in a LTCH cost far more than patients with the same DRG in an ACH, and their length of stay in a LTCH more than double of those with the same DRG in an ACH. There simply is no support for CMS' belief or presumption that patients in LTCHs should be paid like patients in an ACH.

Expanded 25% rule

CMS justifies expansion of the 25% rule to all LTCHs, including grandfathered co-located LTCHs and freestanding LTCHs, based on the presumption that the ACH's discharge to the LTCH presumably is a "premature discharge" if the patient has not reached cost outlier status at the ACH. As noted above, there is no clinical or financial evidence to support CMS' conclusion that the patient is discharged prematurely. RTI, CMS' own contractor investigating these issues, has concluded that it cannot state that LTCHs are substituting for services already paid to IPPS hospitals. Without such evidence the proposal should be withdrawn. In fact, there is significant clinical and financial support presented by NALTH that ACH patients are discharged based upon the expertise of the ACH physician, who has determined that it is appropriate for the patient to receive the specialized services of the LTCH at that time in order to maximize the patient's recovery.

The proposal to expand the 25% rule fails to recognize the many localities in which LTCHs serve a small number of independent ACHs, thereby making it impossible for them to satisfy the 25% rule despite no control or ability to direct or influence the admission patterns.

Mercy Special Care Hospital questions the basis of the 25% threshold itself. CMS has presented no evidence to show that there is any statistical basis for applying such an arbitrary number throughout the country to penalize LTCHs.

Expanding the 25% rule to all LTCHs not only will jeopardize patients' access to appropriate medical care, but the significant and inappropriate financial losses it will generate will all but guarantee the closure of a significant number of LTCHs, thereby preventing access to these unique services by many Medicare beneficiaries.

The proposal to expand the 25% rule to grandfathered hospitals violates the statutory protection given to these hospitals by Congress in recognition of their unique status.

Extreme SSO policy

As noted above, the extreme SSO policy CMS is considering is contrary to clinical and financial realities. Under the current SSO policy a LTCH will at best receive only its cost for a SSO; there is no incentive for a LTCH to admit a patient who is likely to become a SSO. Under the extreme SSO policy being considered a LTCH would undoubtedly lose a significant sum on treating the patient.

Besides not having any financial incentive to admit an extreme SSO, CMS also assumes that LTCHs are able to predict, prior to admission, which patients will become SSOs, much less extreme SSOs. There is no way for LTCHs to make such a prediction. Long-term care hospital patients suffer from multi-system body failures with peaks and valleys in their medical conditions. Their conditions may unpredictability improve or deteriorate at any time. SSO cases are admitted to LTCHs at the appropriate level of care based on the medical judgment of their treating physicians. It is impossible to pre-screen patients and effectively identify which patients may become SSOs. There are a myriad of reasons why a patient admitted to an LTCH may become a SSO. Some SSO cases may achieve medical stability sooner than originally expected. Other cases may become SSOs because they require discharge to an acute hospital due to a deteriorating condition or a new condition which develops subsequent to their admission to an LTCH. Other patients admitted to LTCHs from acute care hospitals may become SSO cases due to their unexpected death. Some patients and their families, after realizing the gravity of their condition, may simply give up and request that aggressive treatment be stopped after admission. Other patients may sign themselves out against medical advice.

There is no basis for a proposed rule which assumes that SSO cases should have remained in acute hospitals. CMS ignores the fact that a significant number of SSO cases

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

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

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

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

In view of the foregoing Mercy Special Care Hospital respectfully requests that CMS not expand the 25% rule to freestanding and grandfathered hospitals, and that it reject the extreme SSO policy under consideration.

Sincerely,

Robert Williams, Administrator

Submitter : **Susan Schuster** **Date: 03/19/2007**

Organization : **Wyoming Valley Health Care System**

Category : **Hospital**

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

See Attachment

CMS-1529-P-18-Attach-1.DOC

#18

Comments on CMS-1529-P

42 CFR Part 412 and 413

Section Addressed: PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION

Dr. Mark McClellan:

Having read the proposed regulation 72 FR 4776 as it relates to the Payment for Direct Graduate Medical Education we are definitively opposed to the changes contemplated by CMS. Specifically, we take extreme exception to the use of office hours as a basis for calculating the denominator in the equation that will be used by CMS to calculate a presumed percentage of time that a physician spends on nonpatient care GME activities. We hereby maintain that the "office time" that a physician records is not accurately reflective of the hours committed or related to said physician's income. This is true for most all physicians that maintain hospital privileges, see patients on an inpatient basis and particularly ineffective in measuring productive hours contributing to salary for proceduralist physicians or surgeons where much of said physician's income is derived from time spent in non-office hours such as hospital rounds, consults, hospital or surgical center procedures, etc. As such, the equation for using "office-hours" as equating to revenue producing hours and applying such equation to national average salaries can, and likely will produce inconsistent and inaccurate hourly pay equivalents.

We similarly object to the use of survey data that could vary by the region of the country and allows for significant inequalities amongst providers. Furthermore, not knowing which survey will be chosen by CMS does not allow teaching programs to begin to estimate the financial impact on their programs nor have the required contracts with the precepting physicians completed prior to the implementation date.

We would like to suggest that given CMS's requirement for hospitals to use the Reasonable Compensation Equivalent (RCE) published tables as the standard and limit by which Part A physician payments are limited on the Hospital Medicare Cost Report, such rates would be more consistent between teaching programs as such are already published and standardized by specialty. We would likewise maintain that since CMS has designated these RCE's as allowable cost limits, CMS should remain consistent and utilize the same RCE tables to arrive at the "reasonably allowable and reportable cost" for the precepting physician's time spent on nonpatient care GME activities.

We would also like to point out that this proposed rule, if finalized in its present state, will create a significant administrative burden on hospitals and physicians in that it will require potentially three or more unique contracts with a single precepting physician given the different salary structures applicable to 1st year vs. 2nd year vs. third year residents as most programs vary a resident's salary based on the year of training.

Lastly, in order to ensure uniformity of the calculation for all programs, there should be a more comprehensive definition of "employee benefits" so that all facilities employ the same methodology for calculating residents' costs and hence producing consistent treatment of this component in the proposed calculations.

Respectfully submitted,

WVHCS-Hospital

Submitter : **Dr. Mahendr Kochar** **Date: 03/20/2007**

Organization : **Medical College of Wisconsin Affiliated Hositals**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1529-P-19-Attach-1.PDF

CMS-1529-P-19-Attach-2.PDF

#19

MEDICAL COLLEGE OF WISCONSIN AFFILIATED HOSPITALS, INC.

MEMORANDUM

DATE: March 20, 2007

TO: Centers for Medicare and Medicaid Services

FROM: Mahendr S. Kochar, MD, MACP
Executive Director, MCWAH
Professor of Medicine and of Pharmacology/Toxicology
Sr. Associate Dean, Graduate Medical Education
Medical College of Wisconsin

SUBJECT: Proposed Rule on Residents Rotating at Non-Hospital Sites (CMS-1529-P)

The proposed rule concerning Medicare DGME/IME payments in a non-hospital site seems to contemplate the scenario where a resident goes to an off site physician office or clinic to be supervised by a physician. The formula to determine whether or not a payment needs to be made to the supervising physician is fairly straight forward. The 90% threshold in the proposed rule would probably result in small payments to some supervising physicians and, in many cases, no payments to a supervising physician.

My concern relates to the impact the proposed rule would have on large teaching hospitals that have close and extensive working relationships with a medical school. The Medical College of Wisconsin and Froedtert Hospital annually have over 550 residents and fellows rotating through 75 clinics at Froedtert Hospital. Forty of these clinics (30 which reside within the four walls of Froedtert) are managed by the Medical College of Wisconsin and, therefore, technically non-hospital based. In any month, a resident may spend time in two or more non-hospital based clinics located in the hospital complex.

Over 450 faculty, who are employed by the Medical College, have responsibility for supervising residents and fellows every month. The permutations of residents to supervising faculty are almost incalculable.

The relationships that a medical school has with its primary teaching hospital vary a great deal. The two institutions must work in harmony to remain financially viable. The hospital certainly supports the cost of supervising faculty in many ways. For example, Froedtert Hospital makes direct payments to the Medical College of Wisconsin departments based on the number of housestaff supported by the hospital for their supervision.

The residency programs are managed by the Medical College of Wisconsin; not the hospital. Rotations are determined based on the accreditation requirements unique to each program. Housestaff are assigned to hospital based and non-hospital based clinics within the hospital in a seamless manner. It is transparent to the program and to the residents that they are assigned to a hospital or to a non-hospital based site.

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Milwaukee WI 53226
(414) 456-4575
FAX (414) 456-6528
Email: gme@mcw.edu

The financial burden that would be placed on the hospital and the medical school to calculate whether or not the supervisory time for an individual resident would be payable to an individual faculty member in the non-hospital site would be staggering. Additional high level accounting staff would need to be employed to work with Program Coordinators to parse out the time spent by each resident in the non-hospital site within the hospital, and then to calculate the potential payment to the supervising physician. Despite this the accuracy of data cannot be guaranteed.

Please keep in mind the fluid nature of teaching in an academic medical center. Residents who may be assigned to a particular clinic may spend a variable amount of time in the clinic based on the number and the needs of patients seen on any given day.

I assume that the CMS wants to ensure that the non-hospital site is receiving funding that it is entitled to from hospitals under the statute. It is very possible that the system being proposed is so arduous that the teaching hospitals will lose millions of dollars for failure to compute the almost incalculable amount that CMS believes the faculty should be paid for supervising residents in a medical center that utilizes hospital and non-hospital based clinics. The proposed rule would not take into account that the two entities may have agreed on a mutually acceptable manner to provide financial support for this supervision.

Last year, CMS made substantial changes to the 2006 proposed rule relating to calculating didactic time recognizing that the proposed rule would have required an inordinate amount of effort for programs to administer. Similarly, the proposed 2007 rule relating to non-hospital site supervision calculations would put a tremendous burden on teaching hospitals and medical schools. We hope that the CMS would pay attention to those of us in the trenches and take a cost-effective approach in addressing this issue.

Submitter : Dr. Charles Driscoll **Date:** 03/20/2007

Organization : Lynchburg Family Medicine Residency

Category : Physician

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

This will be an extreme hardship for family medicine training which combines inpatient and outpatient experiences to train primary health care physicians. We need our residents to see that not all important care occurs within the hospital and cost savings are accomplished when patients are given a higher level of treatment in the community setting.

During their first year the residents maintain a panel of patients that they see for the entire 3 years of training, having office hours 4 hours per week. Our residency is caring for a population that is 65% Medicare/Medicaid and we are the only physicians in the community accepting these as new patients. The residents are also in didactic lectures for 4 hours per week on topics important to medical care in all settings (majority relates to inpatient care). We cannot be penalized for adding this new knowledge to the residents' performance abilities. In the second and third years we use ambulatory experiences in increasing amounts to train the residents in appropriate skills (e.g. slit lamp exams, casting and splinting, joint injections, gynecologic procedures, etc). These skills can transfer to the Medicare population immediately and these things are not done solely within the hospital setting. The proposed cutbacks would severely curtail this training.

Family Medicine training in the community has always had a strong support from and reliance on preceptors, and non-hospital physicians. Most of the physicians also have a hospital practice which is shared with the resident on rotation. We would have an extremely difficult time tracking when the resident is with the preceptor in various settings. This combined outpatient/office/hospital training makes for more appropriate referrals, consultations, timely inpatient care when needed and should lower morbidity and mortality for ill community dwelling elderly. Taking away this training by limiting the hospital's ability to cover the costs of training family medicine residents is a risky move. We may see the lack of skills developing in our residents that then requires more referrals to more costly subspecialty providers. We might see inappropriate delays in consultation and hospitalization. If all training switches to the hospital setting, the core values of family medicine (e.g. compassionate, continuous, comprehensive care) will be sacrificed and be a detriment to the health care system in the future. This country does not need to force a free enterprise of high cost subspecialty care to replace the family physicians who are being trained in an appropriate way health and illness care delivery.

Nationally, we are seeing residency programs close (about 11 last year) because of the economically challenging times and the subsidization of training costs needed. I see this proposal as a trigger for many times that number to close and a mechanism of doing away with primary care services - surely that is not what anybody wants so please reconsider this action.

We are fortunate to still have physicians in our community and across the nation that enjoy giving of their time and talent to educate future family physicians to be better doctors, safer, making less mistakes and providing higher quality care. The hospital allows and accommodates to this mode of training, totally supports the residents financially and offers in kind payments to the volunteers such as free CME and recognition for their needs in information management, etc. I beg that we do not destroy this system and replace it with one requiring burdensome documentation and monetary compensation that the sub-specialist volunteer teachers are not asking for.

Submitter : Dr. Donald Briscoe **Date:** 03/20/2007

Organization : The Methodist Hospital (Houston) Fam Med Residency

Category : Academic

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

This proposal, while clarifying he formula for calculation of payment, codifies concept that adversely effects the funding of medical specialties that rely on non-hospital settings for a significant portion of our education. As program director of a family medicine program, I have my residents rotate in many private physician offices. Approximately half of my residents educational experiences occur in non-hospital settings over the course of their 3 years. These private physicians are true "volunteer" faculty - they neither request nor want payment for the time that they spend in these efforts. They understand that residency programs work on either extremely tight margins or lose money and do not want to direct any money from the educational institutions.

This proposal also requires significant manpower to administrate. This adds significant costs to our graduate medical education system and further depletes the pool of money that could be used for education. The default payment of 3 hours per week at the MGMA average salary for a specialist physician is an overestimate of the time that the physicians spend in teaching outside of normal patient care and would require a very significant loss of revenue to our program. The alternative of having the preceptor log hours and give us his/her true hourly wage is not feasible as well, as physicians have already let us know that they are not willing to provide us with this information.

Please allow the graduate medical education funding to stay where it belongs - with the GME programs to pay for true GME costs.

Submitter : Dr. Rudolph Krafft **Date:** 03/20/2007

Organization : St. Elizabeth Health Center

Category : Physician

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

As faculty of a Family Medicine residency, this proposal threeatens to further decrease residency slots in this critical primary care area. Much of the training in Family Medicine is carried out in community sites with community physicians. At least 50% of the residents time is spent learning these skills in a setting compatible with their future practice (which happens to be the most cost-effective way to provide care). Besides the cost of paying for what has always been a voluntary teaching position, the requirements for calculations regarding time spent teaching and actual amount of money lost are severely taxing to an already strained system. My hospital will look to provide more training at hospital-based sites, which will not provide the residents with the specific education necessary to practice high-quality, cost effective outpatient care (what Family Medicine is all about). Some residencies will close, and primary care will be even less of an option than it currently is, thus shifting care to the more expensive specialist and inpatient care model (where training is usually primarily at inpatient sites, and thus less burdensome and costly for a hospital to administer).
When the country is in the midst of a health care crisis, and costs are increasing while access to preventive and chronic care is decreasing, why would anyone want to make it harder to train the physicians that could help the most with access, lower costs, improve quality, and help to improve the overall health of the coountry? On top of this, my experience is that the preceptors do not decrease their productivity or significantly increase their work time while precepting residents. On many occasions, I have heard that the residents assist with patient care and improve productivity. I also believe that the physician involved with teaching tends to practice better care and remain up-to-date. Continued attempts to increase costs and time burdens for teaching primary care are certainly one reason for the decreased interest in funding primary care residencies and waning interest among medical students. They perceive a lack of interest on the part of the government and a lack of respect for what primary care physicians do. Serious adverse consequences will occur as a result of these changes. If we are forced to calculate a "reasonable" stipend, we must take into account the extreme variablity for each month, specialty, physician, etc. This task is monumental to a small residency like ours.

Submitter : Dr. Lisa Jernigan **Date:** 03/20/2007

Organization : TMH Family Medicine REsidency

Category : Physician

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

The proposed requirement that hospitals must bear the "cost" for non-hospital resident time where we already have volunteer preceptors, in order to justify retaining DME and IME pass through for that resident is simply going to increase the costs, period, associated with graduate medical education. In our situation, where the parent hospital funds all aspects of education with a small percentage contributed by our state, and the rest from generated revenues plus DME/IME, we would be forced to pay those who currently volunteer, fund a position to document that payment and time, to "justify" our DME/IME. Increasing costs all around would only decrease the community hospital ability to do what these scttings do best, train primary care MDs for our nations current and future needs. A poorly trained primary care workforce will dramatically increase costs. There is abundant data that a well functioning primary care base lowers costs of care to everyone, including (especially) Medicare and Medicaid programs. This ruling would injure, possibly mortally, our ability to continue training that base, and is penny wise and pound foolish.

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

The difficulty of administering this rule would administratively cripple our hospital and program, probably costing one full FTE to administer for 30 residents.

Submitter : Dr. Mario Pacheco **Date:** 03/20/2007

Organization : St. Vincent Regional Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am the director of a rural training track for family medicine. 85% of my graduates remain in rural New Mexico to serve the needs of our rural populations. Some of my resident's time is currently spent in the outpatient setting, including at the community health center. Another portion of their time is spent with specialty physicians who volunteer their time to teach my residents. It has been a long-standing tradition that physicians help train the next generation of physicians and we rely very heavily on these volunteer preceptors. As required by our accreditation body, we provide didactic sessions for about 6 hours per week. I believe that the quality of my resident's education is being negatively impacted by the increasing need to keep them in the hospital to remain within the boundaries of the "in housc" rule. My residents do not want to be hospitalists, they want to be family physicians and hopefully prevent the need for so much expensive in-patient care. It would be a shame to be pressured to transition our family medicine program, which has been successful in training rural physicians, into a limited hospitalist fellowship as some of my faculty have suggested to simply remain in full compliance with the Medicare Direct GME rules. Our other alternative would be to simply shut down.

Submitter : Dr. Paul Daluga **Date:** 03/20/2007

Organization : Richard G. Lugar Center for Rural Health

Category : Physician

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

Section B, 5, b Explanation of variables section (3)The Number of Hours Spent in Nonpatient Care Activities in a Week: The logic is faulty and the explanation for the wide range of values seen in the surveys is obvious to anyone who runs a primary care residency. Family Medicine and other primary care residents rarely spend an entire week in a non-hospital setting. They have too many other obligations associated with their primary patient panel.

As an example: A PGY2 Family Medicine resident on a cardiology elective will spend only 4 or 5 half day sessions in the non-hospital cardiologists office(16-20 hours). The remainder of the time the resident will spend in his primary clinic on the hospital campus or in the hospital itself. If you assume three hours of nonpatient care activities per forty hours at the non-hospital site then for the above example the teaching physician only incurs 1.2-1.5 hours of non-patient care activities. Considerably less than using the constant 3 hour figure.

The above example is more common than not in Family Medicine and other primary care programs.

Another much more rare example would be a PGY3 Family Medicine Resident on an 'away' block rotation at a distant non-hospital site that precludes travel back and forth to the main hosptital campus. In this case the resident would spend a designated number of hours at the non-hospital site weekly often 36-40 hours. In this scenario the 3 hours of non-patient care activities would be more accurate but also more rare.Family Medicine residents are only allowed a total of 4 months on 'away' rotations during their entire 36 months of training.

The estimate of the non-patient care activities incurred by the teaching physician makes much more sense if the amount of time the resident spends in the non-hospital physician's office as a multiple of 3/40. As in my first example. 16/40 X 3 = 1.2.

I would be pleased to discuss the further with anyone who has the desire.

Submitter : Dr. Robin Winter **Date:** 03/20/2007

Organization : JFK Medical Center

Category : Physician

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

Family Medicine Residecy Programs utilize a large number of private physicians as teachers. Residents shadow them in their offices to watch how they care for patients. The majority of teaching is done through direct patient care with the attending. There is rarely separate teaching in a lecture format. Therefore, attendings are not spending any time separate from their regular clinic work to teach residents.

In any given week, our residents could be working with 10-20 different physicians in their offices. It would be administratively impossible to calculate all of their supposed teaching costs. This would be very burdensome. Furthermore, these volunteer teachers have residents because they want to teach. It is totally volunteer.

The costs of following the proposed payment system would force us to reduce the number of experiences residents have with private attendings in their offices. These would alter their educational experience.

These rotations always occur in the residents 2nd or 3rd year. Even if they are assigned to be in a private office for a portion of the day, they still come to morning report at the hospital, answer pages and contact patients from the hospital, and take call at the hospital. They also usually have office hours at the hospital as well. Therefore, the hospital continues to pay their full salary and benefits. The hospital also continues funding the educational program including faculty, etc. who interact with residents on a daily basis regardless of their assignment.

Since the residents continue to function as part of the residency during all of their assignments, the hospital is funding the residents entire cost without paying totally volunteer teachers who have no added costs for teaching the residents in their offices.

Submitter : **Date: 03/20/2007**

Organization :

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1529-P-27-Attach-1.DOC

CMS-1529-P-27-Attach-2.DOC

#27

Durham Regional Hospital

DUKE UNIVERSITY HEALTH SYSTEM

March 16, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Re: (CMS-2258-P) Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership, (Vo. 72, N0. 11), January 18, 2006

Dear Ms. Norwalk:

On behalf of Durham Regional Hospital, I appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' proposed rule. We oppose this rule and will highlight the harm its proposed policy changes would cause to our hospital and the patients we serve.

The rule represents a substantial departure from long-standing Medicaid policy by imposing new restrictions on how states fund their Medicaid program. The rule further restricts how states reimburse hospitals. These changes would cause major disruptions to our state Medicaid program and hurt both providers and beneficiaries.

The proposed rule puts forward a new and restrictive definition of "unit of government." In order for a public hospital to meet this new definition, it must demonstrate that it has generally applicable taxing authority or is an integral part of a unit of government that has generally applicable taxing authority. Hospitals that do not meet this new definition would not be allowed to certify expenditures to state Medicaid programs. Nowhere in the Medicaid statute, however, is there any requirement that a "unit of government" have "generally applicable taxing authority." This new restrictive definition would disqualify many long-standing truly public hospitals from certifying their public expenditures. There is no basis in federal statute that supports this proposed change in definition.

Existing federal Medicaid regulations allow North Carolina hospitals to receive payments to offset a portion of the costs incurred when caring for Medicaid patients. Even with these payments, however, hospital Medicaid revenues for most North Carolina hospitals still fall significantly short of allowable Medicaid costs. If the proposed rule is implemented and, as a result, this important hospital funding stream is eliminated, those losses would be exacerbated. Hospitals would be forced either to raise their charges to insured patients or to reduce their costs by eliminating costly but under-reimbursed services. The first choice would raise health insurance costs by an estimated four percent. The second would eliminate needed services, not just for Medicaid patients but also for the entire community. Eliminating those services likely

would result in the elimination of almost 3,000 hospital jobs. That reduced spending and those lost jobs would be felt in local economies, and the resulting economic loss to the State of North Carolina has been estimated at over $600 million and almost 11,000 jobs.

Specifically for Durham Regional Hospital, the loss of this program mean a loss of approximately $4 million annually in payments. With a budgeted operating margin of only $4.6 million this fiscal year, and similar projection for next year, the loss would nearly eliminate any positive operating margin and seriously jeopardize our ability to reinvest in much needed technology and facility upgrades to better serve our community. More importantly, it could jeopardize our ability to provide services to the most vulnerable members of our community, the very people Medicaid was designed to help.

The proposed effective date for this rule is Sept. 1, 2007. If this devastating rule is not withdrawn, North Carolina hospitals will lose approximately $340 million immediately. The results of that would be disastrous, as we have shared in this comment letter. State Medicaid agencies and hospitals would need time to react and plan in order to even partially manage such a huge loss of revenue. The immediate implementation of this rule would result in major disruption of hospital services in our state.

We oppose the rule and strongly urge that CMS permanently withdraw it. If these policy changes are implemented, the state's health care safety net will unravel, and health care services for thousands of our state's most vulnerable people will be jeopardized.

Sincerely,

David P. McQuaid

David P. McQuaid, RPh, MBA, FACHE
Chief Executive Officer

cc: Senator Elizabeth Dole
Senator Richard Burr
Congressman David Price

Submitter : Dr. Randall Longenecker **Date:** 03/20/2007

Organization : The Ohio State University Rural Program

Category : Physician

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

I am the Program Director of an integrated 2-2-2 rural training track in family medicine established July 1, 1998. As such we are implementing the intent of legislation meant to encourage community based training of physicians in an area of need, in our case, rural Ohio. Unfortunately, with the implementation of BBA 1997, BBRA 1999, and MMA 2003, GME and IME payments continue to dwindle to the point that our program is financially unsustainable. Patient revenues have dropped in spite of increasing productivity on the part of faculty and resident physicians, and uncompensated care has risen to more than $450,000 or approximately 35 % of charges annually. In addition, because of diffieulty recruiting physicians to rural training and unforeseen consequences of regulations promulgated by CMS, we are now capped well below our current capacity in spite of Congressional intent in the past 10 years to exempt programs just like ours.

We have three salaried faculty physicians (for a combined non-clinical FTE of 1), a part time clinical psychologist, and a residency coordinator working within the residency program, which now has four residents (with a maximum capacity of 6). Although it is difficult to determine the literal costs of training, I estimate that it costs $100,000 to 150,000 per resident per year, in addition to their salary and benefits, much in line with previously published estimates from programs with greater efficiencies of scale than ours. By rigorous time studies we know that approximately half of our residents time is spent in non-hospital settings.

We would be unable to survive if it were not for the efforts of approximately 20-30 privately employed volunteer teaching faculty practicing within our small town community assisting us in this endeavor (Solo practitioners by the proposed definition; although many share overhead in a group practice arrangement, they are not salaried and are compensated only for direct patient care). We rely on non-physician volunteers as well for training and supervision in community medicine, rehabilitation, and psychiatry. Without detailed and burdensome time studies it is impossible to accurately measure the time spent by these teachers in GME, since it is so integrated into the flow of patient care, a minute here, a minute there. Because of their commitment to the training of physicians for rural practice, these volunteer teaching faculty precept residents in patient eare at their own expense, and if we are required to monetarily compensate them for the extra time it takes to teach, it will most certainly not, further encourage hospitals to shift training to non-hospital settings as intended by the statute. In truth, perhaps our nation cannot afford to pay all or substantially all of the true costs of community based medical education!

The primary cost of resident teaching in addition to resident salaries and benefits, in both the in-hospital and non-hospital or non-provider settings is the cost of oversight, administration, scheduling, and compliance with ACGME, CMS, JCAHO and other regulatory bodies. Time such as the hours spent this evening, fighting for my survival in the face of overwhelmingly complex and contradictory rules, carries a real monetary as well as emotional cost. The proposed methodology, even as simplified, will further complicate and add to the cost of residency training for our program and for most if not all family medicine programs in this country. This is already happening, programs have closed, and the proposed methodology will only make matters worse. From a peak of 35 rural training track programs in February of 2002, there are now only 27.

I applaud the effort to develop a more pragmatic methodology based upon explicit assumptions, but I appeal to CMS to work more directly with Program Directors like myself on the front lines of medical education, to devise a methodology that addresses more directly the true costs of resident education.

Submitter : **Dr. Brian Bacak** **Date: 03/20/2007**

Organization : **Rose Family Medicine**

Category : **Physician**

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

As the program director for a Family Medicine Residency, I would like to protest the proposed change in GME reimbursement legislation. The GME rules for calculating funding are already inordinatcly complex, and thc proposal pushcs training programs to a morc difficult position. Much of our training in FM takcs place in volunteer preceptor officcs outside of hospitals. More so than any other specialty, this training depends on the willingness of outside teachers to committ to take residents in their busy practices, and the resident cducation takes place primarily through cxperience in direct patient contact, with very little "dedicated teaching time". Typically , our residcnts spend small portions within any given time period in a non-hospital setting, with the remaining portion of their time in the family medicine center.

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

The proposed rule complicates the accouting to a degree that is unworkable. For example, a resident doing a non-hosptal elective typically would spend 4 half days in the non-hospital setting, with the remainder in the FMC. At 10 minutes per half day, the non-hospital preceptor would spend 40 minutes a week in GME activities, much less than the 3 hours suggested as a general standard.

Complicating the rules for payment would havc a chilling effect and result in residencics forgoing valuable educational opportunities in non-hospital settings in favor of hospital based busy work at the expense of a valuable experience.

Submitter : Dr. Grant Hoekzema **Date:** 03/21/2007

Organization : Mercy Family Medicine Residency Program

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please consider an alternative IME system that would compensate teaching hospitals that utilize community preceptors that would require those funds be used for resident training, salaries and benefits - that would bring the money to the level at which it is intended - to offset the costs of care that come with training new physicians that burden teaching hospitals.

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

This will be an extremely difficult proposal to implement in our residency program.
In our community training program often residents are in non-hospital settings they utilize many outside preceptors with much variability in sites - up to 4-5 different outside preceptor per resident per year. With 18 residents that means 80-100 different agreements would have to be signed!
Didactic training is provided in our residency mostly in formal lectures by our own faculty - very little formal didactics occur in the non-hospital setting.
The culture of Family Medicine training in the community relies on preceptors to teach our residents what we cannot in a setting that mimics the real world - not the hospital. The preceptors volunteer their time and to have legal agreements of payment would effectively kill the training program.

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

This is an incredibly complex set of rules to implement and I, as a program director of a family practice residency would be hard pressed to understand them let alone implement them in an effective way.

Submitter : Dr. William Short **Date:** 03/21/2007

Organization : Marquette General Health System

Category : Physician

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

I am the program director of one of the most rural based family medicine residency program in the country located in Marquette, Michigan on the shores of Lake Superior. We have now trained over 130 family physicians since our program's inception in 1979. Nearly half are presently practicing in our region, representing 40% of all family physicians serving this very rural part of our country (Michigan's Upper Peninsula).

Our three year curriculum requires that we send our residents to many non-hospital settings to fulfill requirements. The group of volunteer outpatient teachers that we use have been doing this without compaint for decades. Never once has any of this distinguished group of teachers asked for money for this service. Indeed - they look forward to the contact with young learners and tell me that it helps to 'keep me on my toes' and remain up to date in their practice. It is a wonderful relationship which often leads to a future colleagial one after the resident graduates and goes into practice in the region. The resident at that point is well aware of the specialist, what he or she can contribute to the care of the patient, and a referral relationship is well established. It is clearly a win-win.

In addition, the resident is shadowing or seeing the patient ahead of the specialist in their office and may be helping with documentatin - there are no formal didactics expected.

Formal didactics are covered by our paid outpatient teaching faculty at the program as we follow a structured teaching schedule complete with required readings and testing.

We presently utilize over 60 voluntary teachers in the nonhospital setting. Being required to track carefully and pay IME/DME funds to these teachers will become one more unnecessary burden placed on an already overworked administrative support staff. The requirements for residency training have never been more strict, with the expectation to track patient contacts, procedure documentation, communication skill development, professionalism, etc.

We are presently in the most heavily scrutinized budgetary tracking in the history of our program. I shudder at the thought of going to administration to set up a method of payment to these non-hospital setting volunteer teachers. I calculate that this will cost tens of thousands of dollars each year. This will effectively divert funds from other elements of our program, leading to much distress in trying to figure our where to make cuts from a very lean operation. I know very well that our hospital administration will not simply 'find new money' because there is none as we all know is this era of rising medical costs and dropping reimbursement. Ultimately, the quality of what we are doing will be affected and this makes me sad as we have worked very hard to produce our well trained family physicians. I ask that you reconsider this new requirement. Even though it was written with the 'best of intentions', its net result will be to diminish the quality of family medicine education as we shift funds from other areas to cover the new requirement. Thank you.

Submitter : Dr. David Gregory **Date:** 03/21/2007

Organization : CentraHealth-Lynchburg Family Medicine Residency

Category : Physician

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

The proposed changes in respect to out of hospital training applied to our program (and likely the majority of primary care programs that are based in communities using alot of out of hospital training opportunities) creates layer of regulation and documentation that is impossible for us to administratively support.

In our community program, the majority of resident experiences are inpatient and outpatient experiences enmeshed in a way that gives them the best clinical experience, applicable to their eventual - and mostly - outpatient practice. To perform rotations in the in-hospital setting alone is not adequate training for our residents. They learn best in most of their rotations in a balance on in and outpatient settings, but the balance of this is specific to the available preceptors and the time of year of any one rotation resident. Accounting for the detail of time, location and amount of out-of-hospital experience in relationship to the total experience of any rotation among 18 resident physicians (in our program) who are often only with our office 1-4 half days a week, is an administrative impossibility without hiring more personnel and creating an entirely new tracking system for these regulations. Such an endevor will add salary cost and further office space requirements which we are already trying to reduce in order to continue to exist.

The majority of didactic information is given to residents in a non-hospital setting, due to room availability issues and ACGME training requirements that every resident have guaranteed and traced attendence. In an era where we are trying to train outpatient focussed primary care physicians in outpatient settings that give them the most applicable experience to their future practice, the complexity of doing this will be exponentially amplified by the required documentation and the cost-benefit difference of hiring added personnel to do this will worsen our financial viability.

We cannot support this without ceasing to exist, which will impact our ability to continue to be the source of the majority of physicians who serve the most patients in our community (our community will suffer as a result).

Submitter : **Ms. Marilyn Litka-Klein** **Date: 03/21/2007**

Organization : **Michigan Health & Hospital Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Please see the MHA's attached comment letter.

Thank you!

CMS-1529-P-33-Attach-1.DOC

CMS-1529-P-33-Attach-2.DOC

CMS-1529-P-33-Attach-3.DOC

#33

MHA

MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Advocating for hospitals and the patients they serve.

March 21, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Re: Comments on Medicare Program; 2008Proposed Update Rule

Dear Ms. Norwalk:

On behalf of its 145 acute care hospital members and approximately 20 long term acute care hospital members, the Michigan Health & Hospital Association (MHA) welcomes this opportunity to submit comments to the Centers for Medicare & Medicaid Services regarding the Medicare proposed rule published on February 1, 2007. This rule proposes significant changes to the admission practices of long-term acute care hospitals (LTCHs) as well as payment policies that would financially devastate to many facilities.

LTCHs treat severely ill and medically complex patients, offering specialized services and programs of care which are not otherwise available, and serve a significant percentage of Medicare patients residing in Michigan. As such, LTCHs play an integral role in the continuum of care and in ensuring that beneficiaries receive the most beneficial care and are able to return to a high quality of life in the shortest timeframe. The CMS proposed major changes for FY 2008 including:

- Expansion of the 25% rule,
- Adjustment to the short-stay outlier policy,
- Inflationary update less than market-basket,
- Significant increase to the outlier cost threshold

These changes would drastically reduce payments to LTCHs, forcing LTCHs to operate at an additional loss when treating Medicare patients.

Expansion of 25% Rule

Currently LTCHs are in the third year of the transition, that began Oct. 1, 2004, that impacted the Medicare payment rate for discharges exceeding 25% from the host hospital. The proposed rule would **expand the 25% rule to all discharges regardless of the facility's ownership relationship.** For LTCHs located in a two-hospital town, this would virtually reduce their reimbursement level to that of an acute care hospital and likely result in the closure of several LTCHs in Michigan. LTCHs provide services to patients that are not available in an acute hospital. Their success in weaning patients off ventilators and the care provided to extreme wound patients exceeds that of other providers. If the acute care hospitals could achieve these results, they would. The MHA believes that the financial penalties to the LTCHs, who provide these key services to some of the most vulnerable Medicare patients, are extreme and unwarranted. Most of the LTCHs in Michigan utilize Interqual criteria for admission. If these patients meet independent criteria for admission, the Medicare program should not be arbitrarily reducing payment based on ownership of the LTCH. There isn't another Medicare provider that provides appropriate, quality care to a Medicare enrollee and has their payment limited solely because of ownership.

The MHA recommends that the CMS eliminate any expansion of the 25% rule, which would limit payment for care most appropriate based on the patient's medical condition and needs. If the CMS is concerned about inappropriate admissions, we suggest the CMS institute a program to review admissions and deny payment for services that do not meet criteria. At a minimum, the MHA recommends that the CMS eliminate any expansion of the 25% rule to grandfathered hospitals-within-hospitals and freestanding hospitals, which would limit payment for care most appropriate based on the patient's medical condition and needs.

Short-Stay Outlier Proposal

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

Through the SSO policy the CMS has assumed that SSO patients in LTCHs are similar to short-term acute hospital patients assigned to the same DRGs. Data indicates this is to the contrary, SSO patients have a relative case-mix index (CMI) of 2.0592 which is 110 percent higher than the relative CMI of 0.98734 assigned to patients with the same DRGs in short-term acute hospitals. These SSO patients have a higher medical acuity and require more medical resources than are reflected in short-term hospital payments. The higher acuity of LTCH SSO cases is further demonstrated by a higher death rate of 19.61 percent for SSO cases in LTCHs vs. 4.81 percent in acute hospitals.

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

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

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

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

The adoption of the SSO policy would soon negatively impact acute care hospitals if the LTCH refuses to admit these patients. As a result, the acute hospitals will incur significant cost increases to provide the additional care. In addition, many of these patients are ventilator-dependent, and will remain in ICU or other designated special care units, limiting future admissions to the acute care hospital. Potential future

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

admissions to the acute hospital requiring these services may be forced to seek care outside their community, if the special care beds are full, without the attendant care from their primary care physician and less support of family due to travel requirements. Also, maintaining the patient at the acute hospital may result in the patient not receiving the specialized care available at the LTCH. If the acute hospital could wean a patient off a ventilator, they would. Many LTCH have considerable success with this aspect of care, resulting in the patient returning to their primary residence.

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

For the many reasons listed above, the MHA recommends that the CMS eliminate the expansion of the SSO. If the CMS believes LTCH payments are too high for very short length of stay, for example 7 days, the CMS could develop a lower payment for these patients utilizing LTCH patient cost to determine the revised payment level, rather than basing the payment on IPPS which has a totally different patient base and cost structure.

Fiscal Year 2008 Update less than Marketbasket

The CMS' proposal to provide a 0.71% inflationary update, combined with the other proposed changes, will force more LTCHs to operate at a financial loss. It is unfair and unreasonable to deny LTCHs a full inflationary allowance. The lack of an update violates the fundamental principle that Medicare should at a minimum attempt to cover the costs associated with caring for patients, which in this case are the program's most medically complex patients. The CMS' proposal places the ongoing operation of LTCHs in Michigan in jeopardy, reducing access to LTCH services for all citizens.

The MHA recommends that the CMS include a 3.2 percent market basket adjustment in the FY 2008 proposed rule to offset the cost increases incurred by LTCHs in the past year.

Impact of October 1, 2006 DRG Reweighting

Most LTCHs experienced a significant decrease in their CMI as a result of updated DRG weights that became effective Oct. 1, 2006. For many Michigan LTCHs, this represented a payment reduction of five percent that has not been taken into consideration in this proposed rule. LTCHs have already been forced to make operations adjustments to offset this payment reduction while at the same time continuing to provide care to these vulnerable patients.

The MHA recommends that the CMS increase the FY 2007 update factor by 5% (8.2% vs. 3.2%) to remedy the payment reduction that occurred as a result of the DRG reweighting.

Increase in Outlier Threshold

The CMS is proposing a twenty-six percent increase in the cost outlier threshold from the current $14,887 to $18,774. The rationale indicates that the current outlier payments are exceeding the outlier payment pool of 8 percent. It appears that this change is recommended based on mathematics without regard for the acuity of the patients. **LTCHs would only receive these payments if the patient exceeded the outlier threshold, at significant cost to the LTCH.** To propose an adjustment in the threshold will further increase the LTCH loss on each of these patients before the case qualifies as a high-cost outlier.

If the CMS deems an increase in the outlier threshold is warranted, the MHA recommends the CMS raise the outlier threshold at the same rate as the annual update factor.

If you desire clarification of any of these issues, I am available at (517)0703-8603 or via e-mail at mklein@mha.org.

Sincerely,

Marilyn Litka-Klein

Marilyn Litka-Klein
Senior Director, Health Finance

Submitter : **Date: 03/21/2007**

Organization : **American College of Emergency Physicians**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1529-P-34-Attach-1.DOC

#341

American College of
Emergency Physicians
ADVANCING EMERGENCY CARE

March 22, 2007 **Attention: CMS-1529-P**

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-1529-P: Medicare Program: Proposed Changes to the Long Term Care Hospital Prospective Payment System and Hospital Direct and Indirect Graduate Medical Education Policy Changes

Dear Ms. Norwalk:

On behalf of the American College of Emergency Physicians (ACEP), I am pleased to comment on the graduate medical education (GME) policy changes included as part of the proposed rule for LTC Hospitals published in the Federal Register on February 1, 2007. ACEP is a national medical specialty society with more than 25,000 members, dedicated to improving the quality of emergency care through continuing medical education, research, and public education. We appreciate the opportunity to provide the Centers for Medicare & Medicaid Services (CMS) with our comments on GME payment policy and its effect on the training and practice choices of board-certified emergency physicians.

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Graduate Medical Education

Medicare has long authorized payment to teaching hospitals for the direct and indirect costs of training medical residents. In a 1999 regulation, CMS defined "all or substantially all" of the costs for the training program to include the resident's salary and fringe benefits and teaching physician supervisory costs. While the proposed regulation quantifies this requirement, ACEP believes CMS' underlying interpretation of Sec. 1886(h)(4)(E) of the Social Security Act is flawed. CMS repeatedly interprets this section of the law to read as "time residents spend training in sites that are not part of the hospital" when the statute plainly says "Counting Time in Outpatient Settings" for the purposes of GME payment. The hospital emergency department is clearly an outpatient setting and is recognized as such by CMS through its inclusion in the Medicare Outpatient Perspective Payment System.

Further, Sec. 1886(h)(4)(E) states that "such rules shall provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all of the costs for the training program in that setting." For obvious reasons, emergency medicine residents train in hospital emergency departments and this policy interpretation imposes a tremendous disincentive to expand emergency medicine training to rural hospitals where board certified emergency physicians are under-represented.

CMS responded to our comment on this same issue in the April 25, 2006 NPRM for Hospital Inpatient Prospective Payment for FY 2007, saying "We agree that efforts should be made to ensure that (emergency) residency training is occurring at rural facilities so that residents are prepared to work in these environments upon completion of their residency training programs." If CMS is not going to make those "efforts" through GME payment policy, how will this be accomplished? We believe that the statutory language does not preclude payment to the main teaching hospital that incurs all or substantially all of the costs when their residents rotate to small, rural hospital emergency departments as these residents are not serving in more than one hospital "simultaneously." In addition, numerous studies have shown that residents tend to practice in areas where they train, and improving physician distribution is a well-articulated health policy goal of DHHS.

It's important to note that emergency medicine is a relatively young but growing specialty that is very popular with graduating medical students. For the past several years, close to 95 percent of the emergency resident slots have been filled through the annual match program. As we pointed out to CMS staff during our discussions of Sec. 422 of the MMA 2003, Accreditation Council for Graduate Medical Education rules require a certain volume of cases for residency training, and consequently there are no rural training programs. At the same time, the American Hospital Association and other providers have told us there is a tremendous need for residency trained, board-certified emergency physicians in rural areas.

Emergency physicians are trained to treat a large number of illnesses and traumatic injuries using state of the art approaches while many local (non-emergency) physicians who cover rural emergency departments have not received the same level of training. The need for physicians with advanced life saving skills has become even more crucial as fewer and fewer specialists are willing to take call in emergency departments, limiting patient access to advanced levels of care.

As a practical matter, few small rural hospitals that serve as sites for emergency resident rotations want to undertake the burden of becoming teaching hospitals, so the main teaching hospital continues to pay the costs of the residents who rotate to rural institutions. Our residency program directors state that many more teaching hospitals would make rural training available if the primary teaching hospital was reimbursed for the costs incurred while residents rotate to rural hospitals.

We urge CMS to change this policy for emergency and possibly for other hospital-based physicians and allow payment to the main teaching institution for resident time spent at rural hospital rotations. This change could significantly increase the number of residents who choose rural hospital practice.

We appreciate the opportunity to offer these comments, and we would like to discuss our concerns at your earliest convenience. If you have any questions about our comments and recommendations, please contact Barbara Marone, ACEP's Federal Affairs Director at (202) 728-0610, ext. 3017.

Best wishes,

Brian F. Keaton MD

Brian F. Keaton, MD, FACEP
President

Submitter : Mr. Michael Senchak **Date:** 03/21/2007

Organization : Mahoning Valley Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

 #35

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

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

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

Submitter : **Dr. John Purvis** **Date: 03/21/2007**

Organization : **Tallahassee Memorial Family Medicine Residency**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

To whom it may concern:

I have been involved in Family Medicine Residency education for approximately 20 years. The proposal to make Family Medicine Residency Programs pay volunteer faculty for their time is contrary to the long standing educational success of Family Medicine Residency Programs and will add to the financial erosion of our programs.

Since we have a largely ambulatory specialty, much of the training occurs outside the hospital. Paying our preceptors would be difficult logistically and will leave fewer resources to train our residents. It is clear that we will be requiring many more Family Phycicians and other primary care providers in the future and this will make it harder to do.

I see no benefit to this proposal.

Sincerely,
John R. Purvis, M.D.

Submitter : Dr. Thomas Dunlop **Date:** 03/21/2007

Organization : VCMC Family Medicine Residency

Category : Physician

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

We are a county hospital family medicine residency that relies on several community preceptors who wish to volunteer time to teach residents. The proposed regulations actually discourage them from teaching because the paperwork burden and obligations incurred by them upon being (essentially) required to be paid. This will significantly negatively impact the education of our residents.

There is a centuries long tradition of physicians volunteering their time to teach. It is foolish to (in essence) require community preceptors be paid.

Submitter : Dr. Robert Ross **Date:** 03/21/2007

Organization : Cascades East FPR/ Oregon halth and science Univer

Category : Academic

Issue Areas/Comments

Background

Background

We are a Family Medicine Residency Program, with our initial residents entering the training program in the year 1994. We were conceived to train graduating family practice residents to work independently in rural settings in America, and to provide primary medical care to the underserved in Klamath County, Oregon. Since our inception, we have been phenomenally successful at both mandates. 76% of our TOTAL graduates since 1996 are practicing in rural and remote settings in towns of less than 10,000 population (throughout the country), 15% are practicing in FQHC's, 66% are located in HPSA's, and 45% are still delivering babies. These are impressive statistics and are reflective of the nation's need to supply well-trained generalist MD's and DO's to practice in rural locations. Through the residency, we also serve thousands of patients located in our rural community of 40,000 population. We provide 1800+ hospital admissions for our 100 bed hospital, about 20,000 outpatient visits per year, and remain a very popular site for rural resident training in Family Medicine. We have a full program and have matched superb resident candidates through the ERAS matching service every year. Once again, our program filled with high quality US medical school graduates for the upcoming academic year 2007/08.
Every time Congress or CMS institutes rule changes, or the laws and regulations governing post-graduate medical education are changed, we are unintentionally (or intentionally) punished for our success in filling these training needs. For example, we expanded our program in 1995 to 6 resident trainees per year, and the 1996 BBA and subsequent RBBA disallowed us from collecting adequate payment for our training program to cover the increased costs of training our higher numbers of FM residents. The institution of rules regarding payment for volunteer physician teaching already being applied inconsistently by CMS intermediaries threaten our financial stability. We have been required to supply counts of the hours and minutes of preceptor time for all of our teaching physicians, have had to justify use of preceptors (including voluntecr community physicians) and their reimbursement (even though they have been reimbursed using GME funding for years), diverting hundreds of hours of valuable administration time to completion of ridiculously complex and irrational forms and responses, just to maintain our current level of funding. Because of our poorly funded patient population (60% Medicaid, 30% Medicare, 5% uninsured), we are dependent on our IME and DME funding to continue our teaching operations, as well as patient care activities. The institution of complex justification and request to "count" hours and effort towards GME is absurd. FP residencies in general rely on many community and hospital based preceptors, some paid and some voluntary, to deliver education to residents. To expect PGME programs to account for the wide variability in daily teaching tasks including "didactic" teaching hours is unworkable. Most preceptors who supervise residents are intermittently involved throughout the day in direct and indirect educational activities which do not lend themselves to simplistic "time-card" type recording. In one day a preceptor might sit down for 3-4 hours in direct 1 onl conversation and teaching with a resident, and the next be occupied mainly with the supervision on an intermittent basis of patient care activities, perhaps only totalling 2-3 hours, but reflectivc of the "professional" education and practice of medicine. Applying an ill-adapted measurement tool, when at least in our case, the system seems to be working well (our outcomes) would seem a inappropriate diversion of energies, and frankly, impossible. No practicing physician/preceptor, residency program or administration has the time to record the teaching efforts of the team that delivers PGME. Through GME funding we already absorb all of the teaching costs.

GENERAL

GENERAL

4. Stop trying to claw back monics that are being carefully and rationally allocated to resident education, and playing a role in solving the nations health care mess.

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

Once again, CMS has come up with an unworkable and complex system of proposed payment of physicians in non-hospital outpatient sites. The proposal represents an unusual demand on residency programs. For example, we use no fewer than 60 or 70 preceptors to deliver teaching to our residents, and this is in a small community with one hospital. Even without ANY payment, we incurr all of the costs of PGME. We absorb accomodation costs, travel costs, etc. for residents that serve in both our own and other communities, often at a NET GAIN in income for our external preceptors. To be requested to pay for the privilege of them training our residents, and collecting more revenue simultancously, is peculiar aberration of expectations. Even for the preceptors that we pay directly, they practice in many sites, teach both in and outside the hospital setting, sometimes practicc in group setting, and at other times in solo practice. How is it possiblc to keep track of these activities? It is not, and the proposed changes do nothing to address the burdensome inconsistent requirements that we are already trying to meet. In fact, just conforming to the spirit of the regulations (which I suspect is done in most programs) has resultcd in more questions than answers from the intermediaries at CMS, even in our case, when we historically devcloped our own norms for paying community physicians who are impacted by training costs, with the norms in place since our inception in 1994. In fact, this year I was requested to supply detailed hours and times for precepting for duties that occurred 4 ycars ago, even at the time that the primary care exception (for payment to external preceptors) was supposedly in place. How is CMS going to insure responsible and consistent application of thesc lengthy new rules? Proposals such as this seriously impact our ability to deliver high-quality education, and arc going to divert funds from the full-time teachers and programs who are already supplying the majority of administration, didactic teaching and thus the costs of residency training.

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

1. Diversion of administrative time to collection and documentation of unmeasureable teaching hours, with a huge increase in unfunded time for this task.
2. the nced to hire morc support staff for residency programs, whcn cssentially all the costts of PGME are being absorbcd already

3. Diversion of funds from programs to community MD's who in general benefit financially and professionally from the presence of FP residents.

Submitter : Dr. Terry Thompson **Date:** 03/21/2007

Organization : Lynchburg Family Medicine Residency

Category : Physician

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

I am writing this comment to not only support family medicine training, but family medicine as a specialty. We have somehow managed to survive, despite cuts to funding for training residents. Top medical students who might be interested in our field are scared off by the relatively low reimbursements and the long hours. Residency training programs have closed each year, despite calls from government officials and "think tanks" for more medical school seats with new schools being created. Meanwhile, Americans are growing older with the population of "boomers" ready to explode. I would argue that never has the need been greater for well trained family physicians. Studies show that countries that put a premium on family medicine as the foundation specialty have lower costs and better overall patient outcomes and satisfaction. The proposed changes in GME funding will, I am confident, result in many closed programs. I feel that our sponsoring institution, having stood by us through cuts in funding through the years, would be forced to consider dropping our training program. I also feel that we would not be alone. We are at a turning point. We have lines in the sand. We as a country must decide to support family medicine as a specialty. The big name specialties that train exclusively in the hospital setting will not care about this issue. The big losers in this proposal will be the millions of Americans who will not have access to well trained family doctors. We are already suffering with a shortage of family physicians and access to quality primary care is dwindling, especially in light of other medicare cuts. I feel that America needs to build a foundation of family physicians as the building block for health care reform. But we cannot do this with funding cuts, which is basically what this proposal creates. Much of our training occurs outside the hospital walls, like real primary care medicine. We do train and work in the hospital, but most outpatient training occurs in community preceptor offices. Our graduating residents leave our program well prepared and confident to enter the physician workforce. Please keep the pipeline of these graduates flowing so that Americans have access to high quality, cost-effective health care. I am writing to plea with you to not let this proposal go forward. It is my feeling that this proposal would be devastating to family medicine training and our specialty, and ultimately for the health care of all Americans. Thank you.

Submitter : Dr. Mitchell Duininck **Date:** 03/21/2007

Organization : In His IMage Famliy Medicine Residency

Category : Physician

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

As a residency director of a family medicine residency of 30 residents, I coordinate inpatient and outpatient educational experiences. Over the past 20 years of doing this, we have had many physicians in our community volunteer to teach our residents in non-hospital settings. Our residents work alongside these physicians, shadowing them and observing how they care for their patients. The residents watch these volunteer community preceptors in their private practices, some of which are in solo practice settings, others in group practices. The physicians do not adjust their patient schedules to accomodate the residents being there, nor do they work longer hours because of the residents being with them. Any proposed payment to these physicians is not desired by them, nor is calculating teaching time accurately feasible, as all the educational interaction takes place on the go, directly intertwined with patient care. Formal didactics and lectures take place during specific academic conferences in on the inpatient, hospital setting. In order to try to assign time and hours and payment to these volunteer community preceptors which we so heavily rely on for our educational program would require hiring additional administrative staff and administrative burden to an already very difficult situation

Submitter : Dr. Thomas Day **Date:** 03/22/2007

Organization : Duluth Family Medicine Residency

Category : Physician

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

Over the last 30 years, our small residency has provided more family physicians for non-metro Minnesota(153) than any other program. It is an excellent location to teach future family doctors because historical practice patterns of parsimony are coupled with high quality. The local hospitals have tried to replace the waning government funding for graduate education but are trapped because of high numbers of patients covered by CMS insurance plans and the fact that medicare reimbursement for this area is second lowest in the entire country.

The proposal to count hours of resident education at medical clinics was received with enthusiasm. Outpatient skill development is of paramount importance if we are to educate our residents to practice health maintenance and prevention in a wholistic model of care. It is this model of care that will help CMS achieve greater cost-efficiency and better health for enrollees. Continuing to base reimbursement on a method that greatly rewards high-tech heroic care of catastrophic occurrences will perpetuate double-digit inflation of health care costs and poor patient health.

We have always prepared our residents in doctor offices as well as in the hospital. Outpatient elements are clustered in the third year of training much more than the second; with few in the first. We allocate residents to almost 20 different clinics in our community; which adds up to 52 resident-months of off-site education this academic year. Third year residents are knowledgeable and efficient. Teaching specialists often see an increase in patient billings as the resident becomes more integrated into the flow of the clinic.

Your financial model is flawed and will not result in any support for the education of the residents in outpatient medicine. We pay the resident's salary, fringes, and malpractice insurance and also pay the teacher a teaching stipend. However, when these figures are run through the formula published in the proposed rule, we do not achieve the goal of paying 'substantially all' of the costs because the 3-hour DME element (as a fraction of the hours per week that the clinic sees patients and multiplied by the salary of the specialist published in the literature)is way beyond 10% of the total. That means we can't possibly achieve the 90% threshold to be considered 'substantially all.' You need to change your formula or just remove the section from the proposed rule because written as it is only manages to create a mirage of support for the extremely important educational elements that family doctors learn in the community clinics away from the hospital.

Since reimbursement for care delivered by Family Physicians is so meager and the funding for education of Family Medicine residents so tenuous, this is likely a short term issue.

Submitter : **Dr. Russell Robertson** **Date: 03/22/2007**

Organization : **Council on Graduate Medical Education**

Category : **Congressional**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1529-P-43-Attach-1.DOC

#43

Dear Secretary Leavitt:

I am writing to you to share the concerns of the Council on Graduate Medical Education (COGME) regarding a rule proposed February 1, 2007 by the Center for Medicare and Medicaid Services. We are sharing this response with others as required by Part H. Section 799 of Title VII of the Public Health Service Act as amended by Public Law 99-272. This rule, CMS-1529-P – LTCH PPS/DGME Proposed Rule: Annual Payment Rates and Policy Changes, proposes a new revised definition of "all or substantially all" of the costs of graduate medical education programs at a non-hospital site, which would establish 90 percent threshold and offers a formula for calculating this threshold.

In at least four reports to the Secretary of Health and Human Services and to the Congress, COGME has concurred with Congressional efforts to increase GME training in non-hospital settings without reductions in Medicare GME funding. COGME explicitly warned,

> *"A single national policy that allocates funds between hospital and community-based sites using a pre-determined formula does not acknowledge the myriad of existing arrangements for community-based training that could be disrupted."* (Fifteenth Report)

Regarding rewards for community clinician teachers, COGME previously recommended,

> *"The system of rewards must be clear and related to measures of commitment and quality. The specific form of rewards should be determined by each institution, incorporating input from the community teachers themselves as to what constitutes appropriate "value" in recognition of their efforts and achievements."* (Thirteenth Report, March 1999)

We believe that the Congress had similar intent with passage of the Balanced Budget Amendment of 1997 (BBA97). In the present case, the conference

agreement included new permission for hospitals to rotate residents through non-hospital settings, which include primarily ambulatory care settings, without reduction in indirect medical education funds.

COGME expressed concern with the change of definition of and "all or substantially all" in calculating the costs of training in the regulations created after the BBA97. In several site visits, COGME noted that the definition change from including only residents' compensation to residents' compensation and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct GME—was "affecting financial arrangements with community training sites." (Fifteenth Report, December 2000) There is anecdotal evidence that the audits related to this fundamental change are causing reconsideration of training residents outside of hospitals and even frank retrenchment to hospitals. COGME is concerned that the proposed definition would further damage efforts to move training into the settings where most Medicare beneficiaries receive care, and where most future practicing physicians must be prepared to work. Reversing the unintended consequences of the previous definition change has also proven difficult. Bills introduced in the 109th Congress [HR 4403 (Hulshof/Tanner) and S. 2071 (Snowe, Collins, Bingaman, Dorgan)] to revert to the previous definition met stiff resistance due to the considerable cost attributed to the reversal. Once in place, the costs of reversing this new rule and definition will be similarly difficult.

In the proposed rule, CMS acknowledges Congressional intent and states a fundamental belief underpinning the rule: "We further note that the Congress intended to encourage the shift of training to non-hospital settings and we believe this proposed policy change could facilitate further shifts to non-hospital settings." It is our opinion that this belief is flawed and contrary to experience. The proposed rule change will do further damage to an already fragile effort to move resident training and residents' contribution to caring for Medicare beneficiaries into the outpatient setting. This setting-specific rule also has the affect of further harming the primary care training pipeline at a time when the sufficiency of the primary care physician workforce for the Medicare population is already in jeopardy. Lastly, the proposed rule will adversely affect training in rural and underserved settings. Since Medicare beneficiaries locate in rural and underserved areas in higher proportions than the rest of the population, the rule change will work against their interests and those of CMS.

On behalf of COGME, I strongly urge you to reconsider the proposed rule, and to instead consider a return to the definition of "all or substantially all" used prior to 1999.

Sincerely,

Russell Robertson
Chair

Background and Attachments

Excerpted recommendations from COGME related to non-hospital graduate medical education training

Eleventh Report:

Enhance Primary Care Residency Training

A. Provide Medicare DME payments to a wide variety of ambulatory teaching settings, including managed care plans.

B. Include time spent in ambulatory settings outside the hospital in the calculation of Medicare IME payments to hospitals.

C. Make Medicare IME payments to ambulatory settings outside the hospital when ambulatory cost estimates have been developed.

Practitioner competency is dependent upon training in appropriate settings such as in community-based ambulatory sites. Physicians trained to provide primary care in ambulatory settings can provide comprehensive, continuing, longitudinal care to patients. The policy of providing direct and indirect GME payments only for hospital-based residents or DME payments to residents rotating in hospital based ambulatory clinics has restrained appropriate training for all physicians, generalists in particular, to provide such care. Medicare IME payments to ambulatory settings would provide a strong incentive to initiate such training.

Thirteenth Report:

Medical schools and residency training programs should recruit and support community clinician teachers. Faculty members at community teaching sites should be selected for the quality of their medical practice and the excellence of their teaching. They should be paid and otherwise rewarded for their educational activities. Teaching institutions should develop mechanisms to involve community faculty in the design and operation of educational programs.

The system of rewards must be clear and related to measures of commitment and quality. The specific form of rewards should be determined by each institution, incorporating input from the community teachers themselves as to what constitutes appropriate "value" in recognition of their efforts and achievements.

Fourteenth Report:

Assure adequate funding for training in ambulatory settings. Policies related to financing GME in ambulatory sites should be reviewed closely. If necessary, additional policies and programs should be developed to support quality training in ambulatory settings.

Fifteenth Report:

An individual program may have arrangements for teaching with hospital-based clinics, hospital-operated and hospital-affiliated physician practices, community health centers, and individual clinician-physicians in private practice. The financing arrangements differ for each site depending on a number of factors, including payer mix and the intensity of the teaching effort. The financing issues for hospital-based clinics are quite different than those for community clinics and physician practices. The variety of arrangements suggests that decisions on how GME funds should be allocated among the various participants in a given program are best made at the local level. ***A single national policy that allocates funds between hospital and community-based sites using a pre-determined formula does not acknowledge the myriad of existing arrangements for community-based training that could be disrupted.***

There is some evidence That HCFA's revised definition of "all or substantially all of the costs" of Non-hospital training is affecting financial Arrangements with community training Sites.

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Submitter : **Dr. Russell Robertson** **Date: 03/22/2007**

Organization : **COGME**

Category : **Congressional**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

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It is our opinion that this belief is flawed and contrary to experience. The proposed rule change will do further damage to an already fragile effort to move resident training and residents contribution to caring for Medicare beneficiaries into the outpatient setting. This setting-specific rule also has the affect of further harming the primary care training pipeline at a time when the sufficiency of the primary care physician workforce for the Medicare population is already in jeopardy. Lastly, the proposed rule will adversely affect training in rural and underserved settings. Since Medicare beneficiaries locate in rural and underserved areas in higher proportions than the rest of the population, the rule change will work against their interests and those of CMS.

CMS-1529-P-44-Attach-1.PDF

#44

March 22, 2007

Dear Secretary Leavitt:

I am writing to you to share the concerns of the Council on Graduate Medical Education (COGME) regarding a rule proposed February 1, 2007 by the Center for Medicare and Medicaid Services. We are sharing this response with others as required by Part H. Section 799 of Title VII of the Public Health Service Act as amended by Public Law 99-272. This rule, CMS-1529-P – LTCH PPS/DGME Proposed Rule: Annual Payment Rates and Policy Changes, proposes a new revised definition of "all or substantially all" of the costs of graduate medical education programs at a non-hospital site, which would establish 90 percent threshold and offers a formula for calculating this threshold.

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Submitter : Dr. William Crow **Date:** 03/22/2007

Organization : Lynchburg Family Medicine Residency

Category : Physician

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

Family medicine training combines inpatient and outpatient experiences in the training of family medicine residents. Our medical practice is made up of 65% Medicare/Medicaid and our office is the only office in the area accepting new patients. Our residents are exposed to many educational experiences when they are scheduled with outside preceptors. In the second and third years of residency training we use ambulatory experiences in increasing amounts to train the residents in appropriate skills that they will use post-residency. These skills are not done solely in the hospital setting. The proposed cutbacks would significantly impact this training. Our outside preceptors and non-hospital physicians have always been very supportive in our training efforts. I am concerned that if all the residents' training is done in the hospital we will lose the absolute core values of family medicine. This would certainly be a detriment to the health care system and a travesty to our young physicians. This proposal could mean the end of family medicine and the death of family physicians as we know it today. I implore you to reconsider this proposal and do not replace our system (which isn't broken in the first place) with a more cumbersome program requiring a lot of needless documentation and monetary compensation for teachers who enjoy what they are doing and are not asking for this reimbursement.

Submitter : Dr. William Crow **Date:** 03/22/2007

Organization : Lynchburg Family Medicine Residency

Category : Physician

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

Family medicine training combines inpatient and outpatient experiences in the training of family medicine residents. Our medical practice is made up of 65% Medicare/Medicaid and our office is the only office in the area accepting these new patients. Our residents are exposed to many educational experiences when they are scheduled with outside preceptors. In the second and third years of residency training we use ambulatory experiences in increasing amounts to train the residents in appropriate skills that they will use post-residency. These skills are not done solely in the hospital setting. The proposed cutbacks would significantly impact this training. Our outside preceptors and non-hospital physicians have always been very supportive in our training efforts. I am concerned that if all the residents' training is done in the hospital we will lose the absolute core values of family medicine. This would certainly be a detriment to the health care system and a travesty to our young physicians. This proposal could mean the end of family medicine as we know it today. I implore you to reconsider this proposal and do not replace our system (which isn't broken in the first place) with a more cumbersome program requiring a lot of needless documentation and monetary compensation for teachers who enjoy what they are doing and are not asking for this reimbursement.

Submitter : Dr. Jodi Ettare **Date:** 03/22/2007

Organization : Lynchburg Family Medicine Residency Program

Category : Pharmacist

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

This is concerning for our future practitioners. How are we supposed to provide educated and valuable health care when funding for training and quality education of residents as well as other services provided to the public (aka your constituents) is always under attack? It takes time and experienced health care providers to take the time and use their background to train these individuals in and out of the 4 walls of the hospital. Example: we just banned pharmaceutical drug representatives (who provide especially biased drug information) from our program due to influence on prescribing patterns of the residents. I am now the Pharm.D. hired to educate them on unbiased drug information, the good about the generic drugs that are available and help them to understand that more expensive and marketed drugs are not always the best and definitely not necessary for the population as a whole. This type of teaching takes time and money for services but overall will end up saving money for health care in the long run with drug costs. It would be a detriment to our society to cut these indirect education reimbursements. Education is where we need to focus to save money in the long run!

Submitter : **Dr. Dean Gianakos** **Date: 03/22/2007**

Organization : **Lynchburg Family Medicine Residency**

Category : **Physician**

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

The proposed changes will have a drastic, financial impact on Family Medicine residency education. First, it will create greater financial burdens on community hospitals if they are asked to pay more for outpatient teaching. There will be the temptation to keep family medicine residents in the hospital. If this happens, they will miss out on the many outpatient experiences and procedures that define the specialty of family medicine. Weaker family medicine residents will mean more hospital admissions. In other words, it will be harder to keep patients out of the hospital if residents are poorly trained to care for outpatients. Many community hospitals will make the decision to close family medicine programs because the expense will be too great to maintain them. Community health will then suffer from the loss of family physicians, particularly in rural areas of the country.

Please do NOT change the current payment system. As briefly outlined above, I believe primary care medicine in this country would suffer greatly by the proposed change.

Dean Gianakos, MD

Submitter : Glenn Hackbarth **Date:** 03/22/2007

Organization : Medicare Payment Advisory Commission

Category : Congressional

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1529-P-49-Attach-1.DOC

#49

MEDPAC Medicare Payment Advisory Commission

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

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

March 22, 2007

Leslie V. Norwalk, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244-1850

Re: File code CMS-1529-P

Dear Ms. Norwalk:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled *Medicare Program; Prospective Payment System for Long-Term Care Hospitals, RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes; Proposed rule.* We appreciate your staff work on this prospective payment system (PPS), particularly given the competing demands on the agency.

In our comment letter on the proposed changes to the hospital inpatient PPS published in the Federal Register April 2006, we discussed our concern that CMS used different methods to recalibrate the weights for the long-term care hospitals (LTCHs) and acute care hospitals. We applaud your decision to use the same methods to recalibrate weigh for both settings in the future.

Currently, Medicare pays less for certain patients who are admitted to LTCH hospitals within hospitals (HWHs) fro their host hospitals. Most HWHs are paid lower rates when patients admitted from their host hospital make up more than 25 percent of all patients. CMS proposes to extend this rule to freestanding LTCHs so that all LTCHs would be limited as to the number of patients they could admit from any one acute care hospital.

The Commission sees patient and facility criteria to define LTCHs as the best way to target LTCH care to patients w need it and has recommended both facility and patient criteria to define long-term hospital care. CMS contracted wit the Research Triangle Institute (RTI) to assess the feasibility of adopting the Commission's recommendations. The results of the study led RTI to recommend criteria that are similar to our recommendations. Approaches other than criteria, such

as the 25 percent rule, may be administratively less complex but are more arbitrary and increase the risk for unintenc consequences.

We had hoped that CMS would begin implementing criteria in this proposed rule. Two LTCH associations have proposed criteria which each contain elements of what we have recommended. We urge CMS to work with these associations to develop criteria as we have recommended.

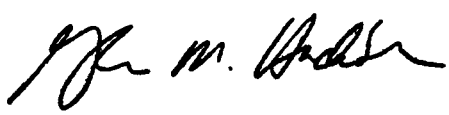
The Commission has also recommended including an adjustment for patient severity in the payment system for acut hospitals. High-severity patients are more likely to be referred to LTCHs. By increasing payment for severely ill patients, a severity adjustment may reduce the need for some referrals to LTCHs.

Finally, the Commission recommended that quality improvement organizations (QIOs) review LTCH admissions fo medical necessity and monitor whether facilities comply with the criteria. CMS states in the proposed rule that the agency does not anticipate expanding QIO activities during the current scope of work. We recommend that the QIO role be expanded in the next scope of work.

MedPAC appreciates the opportunity to comment on the important policy proposals crafted by the Secretary and CM The Commission also values the ongoing cooperation and collaboration between CMS and MedPAC staff on techni policy issues. We look forward to continuing this productive relationship.

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

Sincerely,



Glenn M. Hackbarth
Chairman

GMH/dk/cw

Submitter : **Date: 03/23/2007**

Organization : **American Academy of Neurology**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

CMS-1529-P-50-Attach-1.DOC

#50

1080 Montreal Avenue
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tel: 651.695.1940
fax: 651.695.2791

www.aan.com

March 22, 2007

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: File Code *CMS-1529-P*

Dear Acting Administrator Norwalk,

The American Academy of Neurology (AAN) is a medical specialty society representing over 20,000 neurologists and neuroscience professionals worldwide. The AAN is pleased to offer comments on the CMS proposed rule entitled: *Medicare Program: Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, an Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes* [CMS-1529-P] Federal Register, February 1, 2007. Specifically, the AAN would like to address the proposed payment for direct and indirect graduate medical education (GME).

The AAN is satisfied with CMS' proposed revisions to the current GME payment policy. The changes will make it easier for hospitals to meet the requirement that they pay "all or substantially all" of the teaching costs for rotations at non-hospital sites, which will in turn make it easier to obtain reimbursement for direct and indirect graduate medical education reimbursement.

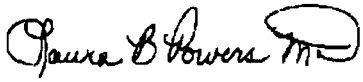
Should the average or median national salary amount be used from AMGA surveys?
The AAN recommends that the median national salary be used in determining payment.

Does the salary amount need to be adjusted by other factors (i.e. regional differences)?
If the survey questions cover a majority of factors associated with salary amounts, the AAN does not feel the need for an additional adjustment. Use of the median national salary amount is generally sufficient to account for other factors associated with salary ranges throughout the country.

Is the three hours divided by the number of hours per week the non-hospital site is open appropriate to determine the amount of time that physicians spend teaching at non-hospital sites?
The AAN is pleased with this recommendation and feels that it is an appropriate formula representative of the time that physician spend teaching at non-hospital sites.

Thank you for your attention to our comments. If you have questions, please contact Katie Kuechenmeister, AAN staff, at 651-695-2783 or kkuechenmeister@aan.com.

Best Regards,



Laura B. Powers, MD, FAAN
Chair, Medical Economics and Management Committee, AAN

Submitter : **Date: 03/23/2007**

Organization : **American Academy of Neurology**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

CMS-1529-P-51-Attach-1.DOC

#51

1080 Montreal Avenue
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www.aan.com

March 22, 2007

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: File Code *CMS-1529-P*

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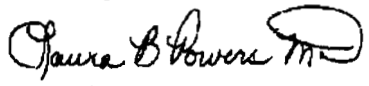
Best Regards,



Laura B. Powers, MD, FAAN
Chair, Medical Economics and Management Committee, AAN

Submitter : Dr. Alex Wilgus **Date:** 03/23/2007

Organization : Dr. Alex Wilgus

Category : Physician

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

I am sure that this rule change, if implemented, will ultimately cause the demise of primary care residency programs around the country, when survey after survey indicates increased demand and need for primary care physicians.

It is patently unfair to those specialties whose aim is in part to actually keep people out of the hospital, such as family medicine, pediatrics, and general internal medicine. You cannot teach residents these skills effectively in a hospital setting, and training them outside of the hospital setting in no way decreases the cost associaed with their training. Yanking funding from the sponsoring institution will only encourage them to withdraw support from these types of residencies, forcing closure.

The result will be a worsening of the already severe overuse and excess cost of emergency rooms for non-critical problems, and increased use and cost of specialist care for medical problems best handled and cost-controlled by primary care doctors.

This is a startlingly short-sighted move to save money at the expense of those physicians who are the most cost-effective providers in our system. It must not be implemented! A much more efficient and cost-effective strategy would be to control overuse of specialists, shift payment priorities to the thought-based as oppsed to procedure-based specialties, and reign in reimbursement for the marginal and ridiculously expensive new medical devices and procedures.

Submitter : **Ms. Marilyn Litka-Klein** **Date: 03/23/2007**

Organization : **Michigan Health & Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1529-P-53-Attach-1.DOC

#53

MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Advocating for hospitals and the patients they serve.

March 23, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: (CMS–1529–P) Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes; Proposed Rule, (Vo. 72, No. 21), February 1, 2007

Dear Ms. Norwalk:

On behalf of its 145 member hospitals, the Michigan Health & Hospital Association (MHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed changes to the graduate medical education (GME) and indirect medical education (IME) payment policies.

The CMS proposes modifications relating to Medicare reimbursement for time residents spend working in non-hospital settings, such as physician offices and clinics. Under current policy, in order for hospitals to receive Medicare reimbursement for residents who rotate through non-hospital settings, hospitals must incur "all or substantially all" of the non-hospital site's costs associated with the residents. The proposed rule is intended to reduce the burden on hospitals by allowing the use of proxy data and lowering the cost threshold that must be incurred in order to demonstrate compliance with the "all or substantially all" requirement.

Based on the recent proposed rule, the CMS would:

- Allow hospitals to assume that three hours of the physicians' time were spent supervising residents each week or to continue collecting actual data;
- Allow hospitals the choice of using national salary data to estimate teaching physicians' costs by specialty or to continue collecting actual data; and

SPENCER JOHNSON, PRESIDENT
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www.mha.org

- Create a minimum threshold whereby hospitals must incur at least 90 percent of the sum of residents' salaries, fringe benefits, the portion of the cost of teaching physicians' salaries and fringe benefits attributable to supervision.

PAYMENT FOR GRADUATE MEDICAL EDUCATION (GME)

Although the MHA appreciates efforts by the CMS to reduce the administrative burden currently imposed on hospitals in demonstrating that they have incurred the required costs, we continue to fundamentally disagree with the CMS' underlying policy. In April 2005, the CMS released a set of "Q&As" explaining that hospitals must pay physicians who train residents in non-hospital settings to compensate them for incurred supervisory costs, even when physicians ***volunteer*** their time. The CMS stated that, "where there is a cost to the non-hospital setting for training residents, we believe that the Medicare program is obligated to ensure that the non-hospital settings receive the funding they are entitled to receive from hospitals under the statute." The government is not customarily involved in private contracts in the Medicare program, nor does it establish such detailed policy when overall program spending is not affected. We are concerned that the proposed extensive requirements are going to inappropriately impact the manner in which medical education is conducted. **The MHA urges the CMS to rescind the requirement that hospitals reimburse physicians who wish to volunteer their time.**

Three Hour Proxy

As a presumptive standard, the CMS proposes allowing hospitals to use three hours per week for calculating costs associated with time spent by a teaching physician in performing non-patient care GME activities at a non-hospital site. To determine the percentage of the average salary associated with the three hours of teaching activities the physician is presumed to spend in non-patient care GME activities, a hospital would divide three hours by the total number of hours the non-hospital site is open each week. The hospital would then multiply this percentage of time spent in non-patient care GME activities by the national average salary of the teaching physician's specialty to calculate the cost associated with the teaching physician's GME time.

In reality, we question whether this will reduce the burden since it will be difficult for hospitals to implement since resident rotations are rarely devoted to a single non-hospital setting for a month or longer. Typically, the resident rotations consist of partial days or partial weeks over a period of time at a non-hospital setting. Residents may have three or four clinics that they regularly visit on a weekly basis. For example, continuity clinics, which are required for internal medicine residents, are generally one half-day per week over three years. If hospitals were to assume three hours of supervisory costs per week per clinic, the estimate would be severely inflated. As a result, hospitals would have no choice but to collect specific information on each clinic, which is unduly burdensome given that smaller programs often contract with 50 non-hospitals sites and

large programs can contract with hundreds. **The MHA recommends that the CMS allow physicians at non-hospital sites to sign attestation forms estimating their average time spent supervising residents per week.**

Salary Proxies

The CMS proposes to allow hospitals to use physician compensation survey data as a proxy to determine the teaching physician costs associated with GME in a program at a non-hospital site, although the hospital could continue to collect the actual data if it chooses. In particular, the CMS requests comments on whether it should select the American Medical Group Association's annual *Medical Group Compensation and Financial Survey* to determine the cost of teaching physicians' time attributable to GME or another physician compensation survey.

The MHA recommends that the CMS consider using reasonable cost equivalents (RCE), which are calculated from the CMS' data, available to the public and are a stable source of salary proxies. If the CMS decides against using RCEs, we would recommend using the Association of American Medical Colleges' (AAMC's) Faculty Roster Survey salary data, which is collected annually. The AAMC has an excellent response rate and can make its data publicly available. Although the AAMC's data set is external to the CMS, it is well-known and stable.

Cost Threshold

The CMS proposes revising the current definition of "all or substantially all of the costs" to require hospitals to incur at least 90 percent of the total costs of residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and benefits attributable to GME.

The MHA believes that 90 percent is higher than "substantially all" suggests. As a result, **the MHA recommends that the CMS reduce this threshold to 75 percent as there is precedent for such a level in other areas of the program and there are no implications for Medicare spending.**

If you have any questions, please feel free to contact me at (517-703-8603 or via email at mklein@mha.org.

Sincerely,

Marilyn Litka-Klein

Marilyn Litka-Klein
Senior Director, Health Finance

Submitter : **Mr. William Walters** **Date: 03/23/2007**

Organization : **Acute Long Term Hospital Association**

Category : **Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1529-P-54-Attach-1.DOC

#54

ALTHA
ACUTE LONG TERM HOSPITAL ASSOCIATION

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INFO@ALTHA.ORG

March 23, 2007

BY ELECTRONIC FILING AND OVERNIGHT MAIL

Hon. Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1529-P
Mail Stop C4-26-5
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: ***Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes; Proposed Rule, 72 Fed. Reg. 4776 (February 1, 2007)***

Dear Ms. Norwalk:

This letter presents comments and recommendations of the Acute Long Term Hospital Association ("ALTHA") to certain aspects of the proposed annual payment rate updates and policy changes under the prospective payment system for long-term acute care hospitals ("LTACH PPS") for rate year ("RY") 2008, which were published by the Centers for Medicare & Medicaid Services ("CMS") on February 1, 2007.

As we discuss more fully below, ALTHA opposes the arbitrary and inappropriate reductions in long-term care hospital ("LTACH") payments that will result if these proposed changes to the LTACH PPS are implemented. ALTHA has analyzed the proposed rule and found that it suffers from a number of recurring problems. First, as with other recent rulemakings affecting LTACHs, CMS continues to rely upon materially flawed and incomplete data in developing their proposed changes to LTACH payments for RY 2008. ALTHA's analysis shows that the assumptions CMS made in developing its proposed changes to LTACH payments for RY 2008 are incorrect due to (i) the type of data that CMS cites as support, which in many cases does not provide the information CMS says it does; (ii) the lack of a reference to specific data for interested parties to evaluate; (iii) the failure to consider other data, as provided herein, that dispute the analytical foundation for CMS's proposals; and (iv) the lack of current data reflecting the impact of recent adjustments to the LTACH PPS to show whether those adjustments are achieving CMS's stated policy goals before more onerous policies are finalized. Second, ALTHA does not believe that CMS has seriously considered the legal and equitable issues which this proposed rule raises with regard to patient freedom of choice, physician medical decision-making, and the disparate impact on LTACHs in underserved areas.

ALTHA continues to recommend that CMS reconsider its proposed changes to the LTACH PPS in light of the Medicare Payment Advisory Commission ("MedPAC") recommendations in June 2004

that the certification criteria for the Medicare LTACH provider category be strengthened to ensure that LTACH 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 LTACH payments to hospitals that are truly caring for a medically complex patient population. Unfortunately, the proposals that CMS advances in this proposed rule continue to rely on arbitrary and unproven payment reductions that will not achieve the stated policy goals and will significantly hinder the ability of many LTACHs to continue to provide quality patient care to Medicare beneficiaries. More comprehensive LTACH certification criteria are the correct approach if quality of care is to be encouraged, not arbitrary payment reductions.

First and foremost, CMS should reconsider its proposed policy for extending the so-called "25% rule" from hospitals-within-hospitals ("HIHs") to all LTACHs, and its proposed policy to enlarge the category of short-stay outlier ("SSO") cases. To the extent that CMS is concerned about "inappropriate" admissions to LTACHs, it should implement non-payment approaches such as pre-admission physician certifications, uniform admission screening criteria, and more extensive Quality Improvement Organization ("QIO") reviews. 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. Moreover, the cumulative effect of these policies will result in negative LTACH margins, based upon the most recent MedPAC data. Establishing payment policies that reimburse Medicare providers below the cost of care violates a basic premise of the Medicare program.

ALTHA represents the nation's leading LTACHs 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 LTACH hospitals across the United States, constituting over two-thirds of this provider community nationwide. The proposed policies and reimbursement changes in the proposed rule will have a direct, adverse impact on the LTACHs operated by ALTHA members. We appreciate the opportunity to express our concerns with the proposed policy and trust that CMS will carefully consider each of the issues raised in this letter.

I. Executive Summary

The proposed rule takes the next step in a series of calculated efforts by CMS to reverse the growth in the number of LTACHs and reduce reimbursement to LTACHs for caring for Medicare beneficiaries suffering from complex medical conditions that require long hospital stays. In continuing to reduce payment rates and expose additional LTACH cases to payment rates for short-term acute care hospitals ("STACHs"), CMS fails to account for prior adjustments to the LTACH PPS in the past few years that have already halted, and possibly reversed, the growth of new LTACHs. CMS's own data shows that growth in the number of LTACHs has stopped. According to the December 2006 CMS Provider of Service file, there was a net reduction of one LTACH in 2006. With regard to margins, MedPAC estimated LTACH margins to be at or near zero even before the proposed rule was released. A comprehensive analysis of the proposed rule reveals that LTACH margins will be between negative 3.7% and negative 5.7% if the proposed policies are finalized. This reduction in payment significantly below the cost of providing care will dramatically impact the ability of LTACHs to provide quality services to Medicare beneficiaries. CMS must not engage in this type of punitive rulemaking when Congress has provided express statutory authority for LTACHs and a PPS that reasonably reimburses LTACHs for the cost of care.

In the preamble to the proposed rule, CMS offers one primary justification in support of its two most significant policy proposals to extend the so-called "25% rule" from HIHs to all LTACHs and to enlarge the category of SSO cases: its belief that LTACHs are acting like units of STACHs, such that it believes that patients admitted to LTACHs are continuing the same episode of care that began during the patient's stay in the referring STACH. However, CMS fails to provide credible evidence that these

interrelated issues are, in fact, occurring. CMS's own independent consultant, RTI International, has stated that the issue of LTACHs offering a continuation of a single episode of care is "poorly understood." Through our own analysis of publicly available data, discussed below, we found the *opposite* to be true – STACHs are not discharging patients to LTACHs "early" and Medicare is *not* paying twice for a single episode of care. CMS's own data shows that LTACH patients have different characteristics than are evident during their preceding stay in a STACH. The data also shows that LTACH patients receive different treatments to address different clinical needs following a stay in a STACH. Furthermore, differences in the medical complexity and average length of stay of LTACH cases substantiate reimbursement at the LTACH PPS rate, not the inpatient PPS rate for STACHs. CMS also has not presented evidence that LTACHs are acting like units of general acute care hospitals. As discussed below, the existence of primary referral and discharge relationships between LTACHs and STACHs are both required by law and necessary to facilitate quality patient care in the most appropriate patient care setting.

ALTHA has serious concerns about a number of unintended consequences associated with CMS's proposal to expand the 25% rule to freestanding LTACHs and grandfathered LTACH HIHs and satellite facilities. CMS is proposing to expand the existing payment limitation threshold to any LTACH or satellite of an LTACH that discharges during a single cost reporting period more than 25% (or applicable percentage for rural, single-urban, or MSA-dominant hospitals) of Medicare patients admitted from any non-co-located individual hospital. The original 25% rule was adopted by CMS in regulations that were recently published on August 11, 2004 and have yet to be fully implemented. Until the existing 25% rule is fully implemented, it is impossible to know the full impact of the existing rule on LTACHs and the impact that rule is having on patient access and quality of care for Medicare beneficiaries. What we do know is that the existing 25% rule, in combination with CMS's other payment policies, has reduced growth in the net number of new LTACHs to negative numbers. Yet CMS is advancing a policy that, without question, will further restrict patient choice and diminish access to quality care by imposing a rigid, arbitrary, and extremely limiting quota on the number patients who will be fairly reimbursed at the LTACH PPS rates.

Further, limitations on the number of patients admitted from a single hospital undermine physician discretion to determine what clinical setting is in the best interest of the patient. Through its other policies, CMS has repeatedly reinforced a patient's right to choose a health care provider. But this proposed policy will have a discriminatory impact on LTACHs and Medicare beneficiaries. For no clinical reason, patients in the 26th percentile and higher will be paid like general acute care patients when their complex medical needs and relatively long stays require LTACH care. Perhaps the hardest hit will be LTACHs located in underserved areas or communities with less than four general acute care hospitals where LTACHs lack the ability to offset reduced patient referrals from one hospital with a greater number of LTACH-level patients from other hospitals. These results have nothing to do with the care required by a particular patient or the quality of care offered by a particular LTACH, and have everything to do with the unintended consequences that will result from the arbitrary nature of establishing a payment limitation that has no relevance to patient or facility level criteria. For these reasons, the proposed rule not only penalizes LTACH providers, it penalizes Medicare beneficiaries. ALTHA encourages CMS not to finalize, or at the very least to postpone, any expansion of the current 25% rule to freestanding and grandfathered LTACHs.

ALTHA is concerned that CMS has set forth yet another proposal to expand the class of SSOs that would effectively be paid at STACH rates without understanding the types of patients that would be treated as SSOs under the proposed policy. In the proposed rule, CMS indicates that it is considering lowering LTACH payment to the IPPS rate for cases with a length of stay that is less than the average length of stay plus one standard deviation for the same DRG under IPPS. Cases with a covered length of stay less than or equal to one standard deviation for the same DRG under IPPS would be paid at an amount comparable to the IPPS per diem.

As noted above, CMS offers the same justification for this short stay policy as is offered for the 25% rule policy. CMS believes that LTACH patients with "very short" lengths of stay have not completed their "episode of care" and should not have left the STACH. CMS's own data provides no support for this "belief." Moreover, rather than capture truly short-stay patients with lengths of stay that approximate STACH patient lengths of stay, as suggested, this policy would actually have the perverse effect of treating as SSOs many LTACH patients with lengths of stay that approach the 25-day average for LTACH certification (*e.g.*, 21 days, 23 days). ALTHA strongly encourages CMS not to make further changes in the SSO policy based upon the data provided herein and because MedPAR data is not available yet to evaluate whether the SSO policy changes put into effect last year are achieving the desired policy goals. CMS has produced no study or analysis in the proposed rule showing that inappropriate admissions constitute a material portion of SSO cases. To the contrary, the data presented below demonstrates that the opposite is true: SSO cases are, in fact, appropriate for admission to LTACHs for a number of reasons, including the fact that even shorter stay LTACHs patients are more severely ill than comparable STACH patients; difficulty in screening SSOs from admission to LTACHs based upon clinical criteria at the time of discharge from the referring hospital; the inability of clinicians to predict when LTACH patients will expire; and the inherent averaging of patient lengths of stay that is the foundation of the current LTACH certification criteria and PPS. 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. CMS should be well aware that the rate of payment for these cases will be insufficient to cover LTACHs' reasonable and necessary costs in providing care to this segment of LTACH patients.

The proposed policies violate the statutory requirement that CMS reimburse LTACHs on a per discharge basis that reflects the reasonable and necessary cost of providing services in a hospital having an *average* length of stay of greater than 25 days. The proposed policies will continue to erode the LTACH PPS by reimbursing LTACHs for fewer and fewer medically complex patients at the LTACH PPS rates. The LTACH PPS must adequately reimburse LTACHs for the costs they incur in caring for Medicare beneficiaries. The cumulative effect of the proposed changes to the LTACH PPS will be to bring LTACH reimbursement below the cost of care. This level of reimbursement is unsustainable and will inevitably result in a decrease in access to LTACH services in spite of the increasing number of Medicare beneficiaries and the overall aging of the country's population. The Congress, the LTACH industry, MedPAC, and RTI International all agree that LTACHs serve an important role in caring for medically complex patients who need long-term hospital stays. CMS should develop policies that reflect this consensus. We encourage CMS to work with the Congress to develop meaningful facility and patient certification criteria for LTACHs, as proposed in H.R. 562 and S. 338.

ALTHA objects to CMS's proposal to provide less than the full market basket update of 3.2% for RY 2008. An increase of less than the market basket will not account for the cost of goods and services required to deliver LTACH services and will result in rates below the cost of care. CMS cannot use an unsupported measure like "apparent" case-mix, something it has never adequately justified with publicly-available data, to reduce the market basket increase. Moreover, CMS relies on an estimate of "apparent" case mix from a dated study of acute care hospitals. Case-mix is not a factor that is relevant to the price of inputs generally, or the cost of providing LTACH services in RY 2008 specifically. The full market basket update is an accurate reflection of items and services purchased to treat Medicare beneficiaries and is necessary to account for the rising cost of inputs. Any relevance that so-called "apparent" case mix may have is in the context of annual re-weighting of the LTC-DRGs, not the market basket update. The federal rate must be updated in accordance with the market basket to keep LTACH payment rates in step with the higher cost of price inputs.

In summary, ALTHA urges CMS to carefully consider the comments and data provided in this letter and to reexamine the policies advanced in the proposed rule. The types of patients admitted to LTACHs, the care provided during an LTACH stay, and the relationships that LTACHs have with STACHs show that Medicare is not paying twice for a single episode of care. LTACHs serve a distinct and important purpose in the health care continuum. CMS's payment policies should reflect this in a

manner that fairly compensates LTACHs for the care they provide to thousands of Medicare beneficiaries across the nation.

II. Discussion

A. Expansion of the "25% Rule" to Freestanding LTACHs

1. Summary of Proposal

In the IPPS final rule for fiscal year 2005, CMS established a special payment provision at section 412.534 for LTACHs that are HIHs and satellites of LTACHs. An HIH is defined as a hospital that occupies space in a building also used by another hospital, or in one or more separate buildings located on the same campus as buildings used by another hospital. A satellite is defined as part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital. Under section 412.534 discharges from an HIH or satellite that were admitted from the co-located hospital that exceed 25% of the total Medicare discharges of the HIH or satellite during a single cost reporting period are paid at the lesser of the otherwise payable amount under LTACH PPS or the amount equivalent to what Medicare would otherwise pay under IPPS.

HIHs and satellites located in rural areas may discharge, during a single cost reporting period, up to 50% of the LTACH's total Medicare discharges from the co-located hospital before the HIH or satellite is subject to a payment adjustment. Likewise, if the referring hospital is the only other hospital in the Metropolitan Statistical Area ("MSA") or an MSA dominant hospital, the HIH or satellite may discharge up to 50% of the LTACH's total Medicare discharges during the cost reporting period from the referring co-located hospital before the HIH or satellite is subject to a payment adjustment. Patients on whose behalf a Medicare outlier payment was made at the referring hospital are not counted toward the 25% threshold, or applicable threshold for rural, urban-single, or MSA-dominant hospitals.

In the proposed rule, CMS would expand the payment limitation threshold to any LTACH or satellite of an LTACH that discharges during a single cost reporting period more than 25% (or applicable percentage for rural, single-urban, or MSA-dominant hospitals) of Medicare patients admitted from any non-co-located individual hospital. The proposed rule would apply to each individual hospital referral source to the LTACH and affect Medicare discharges from all LTACHs or LTACH satellites, regardless of whether the patient was admitted from a hospital located in the same building or on the same campus of the LTACH or satellite.

CMS proposes to phase in the expansion of the 25% rule together with the phase-in of the current 25% rule for LTACH HIHs and satellites of LTACHs. For LTACHs and satellites with cost reporting periods beginning on or after July 1, 2007 and before October 1, 2007, the percentage of Medicare discharges admitted from the referring hospital with no payment adjustment may not exceed the lesser of the percentage of the LTACH or satellite's Medicare discharges admitted from the referring hospital during the FY 2005 cost reporting period or 50%. For cost reporting periods beginning on or after October 1, 2007, the percentage of Medicare discharges admitted from any referring hospital without a payment adjustment may not exceed 25% (or the applicable percentage).

CMS estimates that the expansion of the 25% rule will result in a 2.2% reduction in aggregate LTACH payments for RY 2008.

2. ALTHA Response

a. CMS Proposes to Expand the Payment Limitation Threshold Before the Existing 25% Rule Is Fully Implemented and, Importantly, Before the Impact of the Existing 25% Rule Can Be Measured

CMS's proposal to expand the payment limitation threshold to any LTACH or satellite of an LTACH is premature. The existing 25% rule became effective as recently as October 1, 2004 and has yet to be fully implemented. LTACHs existing on or before October 1, 2004 are not subject to the full impact of the 25% rule until their first cost reporting period beginning on or after October 1, 2007. During the transition period, CMS does not have the data required to confirm that the 25% rule is achieving the stated policy goals. Without complete data, CMS can not know whether the existing application of the 25% rule is achieving these goals without having adverse effects on patient care. For a credible analysis, CMS must examine the effect of the existing 25% rule at the conclusion of the transition period and postpone any further application of this rule.

The proposal to expand the 25% rule requires that, at most, 25% of an LTACH's admissions (or applicable percentage for rural, single-urban, or MSA-dominant hospitals) from any referring hospital will be paid at the full LTACH PPS rate. CMS believes this will reduce incentives for STACHs to maximize Medicare payments and, consequently, the likelihood that STACHs will transfer beneficiaries to LTACHs before they receive a full episode of care. We have not found evidence that STACHs are prematurely discharging patients to LTACHs, or that LTACHs are acting as extension sites or units of STACHs. In fact, the data provided below disputes these assumptions.

We remind CMS that in last year's proposed rule addressing the annual payment rate update for RY 2007, which was published January 27, 2006, CMS raised the same concern that freestanding LTACHs were involved in improper patient shifting. In the preamble to the RY 2007 proposed rule, CMS cited three data sources for its statements about alleged improper patient shifting involving freestanding LTACHs. None of the sources cited provide convincing evidence that freestanding LTACHs are involved in patient shifting. The first data source was a Lewin Group study that CMS states was commissioned by an LTACH trade association. CMS does not state that it reviewed the study or the underlying data – only that CMS was informed by the association of certain findings from the study. In fact, the Lewin Group study was commissioned by the National Association of Long Term Hospitals ("NALTH"). In NALTH's comments to CMS about this proposed rule, they took issue with the conclusions that CMS reached from this study for failing to recognize the demographics of referrals to post-acute providers throughout the United States. See NALTH Comments, dated March 13, 2006, pgs. 24-25. NALTH requested that CMS correct the public record with regard to this study and fully report the Lewin Group's conclusions.

The second source of data CMS referred to was 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 provided 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 was an analysis that CMS stated it conducted of sole-source relationships between acute care hospitals and non-co-located LTACHs. CMS presented certain data points from the FY 2004 and FY 2005 MedPAR files: 63.7% of 201 freestanding LTACHs have at least 25% of their Medicare discharges admitted from a sole acute care hospital; for 23.9% of freestanding LTACHs, CMS says the number of referrals is 50% or more; and 6.5% of freestanding LTACHs obtain 75% or more of their referrals from a single hospital source. CMS, however, failed 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 was impossible to know whether the percentages CMS cites from its analysis are unusual in the hospital sector.

CMS has not advanced more convincing data with this proposed rule. Thus, CMS is not in a position to make further policy changes pertaining to freestanding LTACHs without a more thorough

and meaningful analysis of available data and the impact of the existing 25% rule after it has been fully implemented.

We continue to believe that the 25% rule is an ineffective method of ensuring the appropriateness of referrals from STACHs to LTACHs. CMS should focus its resources on enforcing its existing requirements for HIHs at 42 C.F.R. § 412.22(e), and working with LTACHs and the Congress to implement comprehensive LTACH certification criteria, rather than take the premature step of expanding this payment penalty to freestanding LTACHs. Until the transition period for the HIH 25% rule is completed for all LTACH 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.

b. CMS Has Failed to Provide Credible Evidence to Support the Allegations that Medicare Is Paying Twice for the Same Episode of Care, or Freestanding LTACHs are Acting as Units of Referring Hospitals

The proposal to expand the 25% rule to non-co-located LTACHs and grandfathered HIHs is based on CMS's assumption that all LTACHs are effectively acting as extensions or units of STACHs such that patients are not receiving a full episode of care at the STACH. In other words, CMS asserts that STACHs are discharging patients to LTACHs "early" prior to completing their episode of care. CMS provides no data or evidence in the proposed rule to support either assumption, or the related assertions that Medicare is paying twice for the same episode of care, or that "patient shifting" is occurring between LTACHs and STACHs. CMS's presumption that "prematurely discharged patients" are being routinely admitted to LTACHs is not supported by available data. The only evidence that CMS offers to support this assumption is the percentage of referrals that LTACHs receive from primary referral sources. This data, taken alone, does not support the conclusion that Medicare is paying twice for a single episode of care. Indeed, we seriously question whether CMS has any basis for extending the 25% rule to freestanding LTACHs and grandfathered HIHs given the lack of evidence offered in support of the original 25% rule.

(1) CMS's Own Research Contractor Concluded that Existing Data Do Not Support the Conclusion that Medicare Is Paying "Twice" for a Single Episode of Care

CMS's primary rationale for expanding the 25% rule to freestanding LTACHs is the assumption that these providers effectively function as "units" of STACHs such that Medicare is paying "twice" for a single episode of care. Despite repeatedly citing this concern, CMS's own researchers have not found evidence that any LTACHs, let alone freestanding LTACHs are acting as units of STACHs. In 2004, CMS retained The Research Triangle Institute ("RTI") to study the feasibility of implementing MedPAC's recommendation to revise LTACH certification criteria. RTI specifically examined the extent to which STACHs and LTACHs serve as "substitutes" such that Medicare could be paying twice for a single episode of care. Based on their analysis to date, RTI concluded that this issue is "poorly understood."[1] In fact, RTI plans to examine this issue further in "Phase III" of its work for CMS. It is premature to draw any conclusions and entirely inappropriate for CMS to finalize such a dramatic change in payment policy for LTACHs when its own contractor has concluded that CMS's purported rationale for the rule is "poorly understood" and not yet supported by data.

(2) Hospital Discharge and Referral Relationships Are Required by Law and Are Not Evidence of Inappropriate Admissions

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[1] See RTI Report, 2006, pgs. 54-55.

All hospitals establish referral and discharge relationships with hospitals and other types of providers in order to facilitate quality patient care in the most appropriate patient care setting. LTACHs and other Medicare hospital providers are required under state and federal laws to establish referral and discharge relationships with other hospitals and post-acute care providers. These relationships are necessary to ensure that patients receive the best quality care in the most appropriate patient care setting. Upon discharge, the Medicare regulation at 42 C.F.R. § 482.43(d) requires participating hospitals to "transfer or refer patients . . . to appropriate facilities, agencies, or outpatient services, as needed, for follow up ancillary care" as a condition of participation. This requirement necessitates that hospitals establish referral and discharge relationships, by agreement or otherwise, with other providers. This requirement also implies that the patient's attending physician, in conjunction with the hospital's discharge planner, determines where the patient should be discharged to receive appropriate care at that time. The legitimacy and the practicality of such relationships, specifically in the context of general acute care hospitals that discharge and transfer patients to LTACHs, also is implicit in CMS's post-acute care transfer policy as outlined in the Medicare Claims Processing Manual, chapter 3, section 40.2.4 (CMS Pub. 100-04).

Further, the Emergency Medical Treatment and Active Labor Act ("EMTALA") prohibits participating hospitals with the capacity to treat from refusing to accept the transfer of a patient in need of emergency medical services from a referral source. See 42 U.S.C. 1395dd(g); 42 C.F.R. 489.24(f) ("A participating hospital that has specialized capabilities or facilities . . . may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.") Many states require hospitals that do not provide emergency services, as a condition of licensure, to contract with another hospital to provide emergency services when such services are needed. See, e.g., Fla. Stat. Ann. § 395.10413(d)("Every hospital shall ensure the provision of services within the service capability of the hospital, at all times, either directly or indirectly through an arrangement with another hospital, through an arrangement with one or more physicians, or as otherwise made through prior arrangements. A hospital may enter into an agreement with another hospital for purposes of meeting its service capability requirement, and appropriate compensation or other reasonable conditions may be negotiated for these backup services."). Other states require a written agreement for the provision of any special services (including emergency) that are not otherwise available. See e.g., 25 Tex. Admin. Code § 133.22 ("if the [hospital license] application is for a [LTACH] license, a copy of a written agreement the [LTACH] has entered into with a general hospital which provides for the prompt transfer to and the admission by the general hospital of any patient when special services are needed but are unavailable at the [LTACH]. This agreement is required and is separate from any voluntary patient transfer agreements the hospital may enter into in accordance with § 133.61 of this title (relating to Hospital Patient Transfer Agreements)"), See also 25 Tex. Admin. Code § 133.44 (describing the substantive requirements for a mandatory patient transfer agreement). Still other states require hospitals to provide a certain level of care, and where the hospital does not or can not provide that level of care directly, it must make it available to the patient through formal referral arrangements with other providers. See e.g., Ill. Admin. Code tit. 77, § 250.820 ("It is important that each hospital select in writing the level of restorative or rehabilitation services which it will provide in accord with license. Those levels not provided directly by the hospital must be made accessible to every patient through formal referral mechanisms or contractual arrangements."). The Joint Commission and Medicare surveyors have emphasized patient transfer as an aspect of care requiring great vigilance and sophistication, and it is widely accepted that better patient outcomes are achieved when providers encounter a sufficient number of cases in areas of complex medical care.

These laws and other considerations refute CMS's presumption that LTACHs are merely functioning as units of other hospitals because they may receive a significant number of patient referrals from a single hospital referral source. The mere existence of referral relationships between providers, and the resulting patient referrals admitted to LTACHs, do not prove that LTACHs are "gaming" the payment system. Rather, they show that the system works, and both the referring hospitals and LTACHs are acting in accordance with state and federal laws.

(3) Aggregate Data Refutes the Assumption that LTACH Patients Have Continued the Same Episode of Care that Began In the STACH

There is no data to support the conclusion that LTACH patients have continued the same episode of care that began in the STACH. In fact, as illustrated in Table 1 below, 2005 MedPAR data shows that, among discharges from all STACHs (12,949,045), 76% received the full payment without an outlier payment and an additional 2% received both the full payment and an outlier payment. Together, discharges from STACHs that received at least a full payment accounted for a total of 78% of all STACH discharges. Similarly, 68% of STACH discharges to LTACHs (112,243) received the full payment without outlier payment and an additional 10% received both the full payment plus an outlier payment. Together, discharges from STACHs to LTACHs that received at least a full payment accounted for a total of 78% of all such discharges. The fact that the percentage of STACH discharges to LTACHs that receive a full payment is substantially the same as all discharges establishes that patients are receiving a full episode of care at the same rate regardless of a subsequent admission to a LTACH. This data contradicts the assumptions on which CMS bases the proposed rule.

Table 1

2005 MedPAR STACH Discharges			DRG Type	
Payment Type	**Total**		**Post Acute**	**Non-Post Acute**
Post Acute Adjustment *	2,820,297	21.8%	2,820,297	
High Cost Outlier **	214,854	1.7%	162,303	52,551
Post Acute Adjusted and Cost Outlier	4,005	0.0%	4,005	
Normal	9,909,889	76.5%	4,769,076	5,140,813
Total	**12,949,045**	**100.0%**	**7,755,681**	**5,193,364**
			59.9%	40.1%
Post Acute Adjustment *	23,759	21.2%	23,759	
High Cost Outlier **	11,917	10.6%	9,903	2,014
Post Acute Adjusted and Cost Outlier	628	0.6%	628	
Normal	75,939	67.7%	59,287	16,652
Total	**112,243**	**100.0%**	**93,577**	**18,666**
			83.4%	16.6%
Post Acute Adjustment *	2,796,538	21.8%	2,796,538	
High Cost Outlier **	202,937	1.6%	152,400	50,537
Post Acute Adjusted and Cost Outlier	3,377	0.0%	3,377	
Normal	9,833,950	76.6%	4,709,789	5,124,161
Total	**12,836,802**	**100.0%**	**7,662,104**	**5,174,698**
			59.7%	40.3%
* LOS < (GMLOS - 1)				
** Received Outlier Payment				

The analysis of the 2005 MedPAR data in Table 1 demonstrates that it is erroneous for CMS to assert that patients with the same DRG upon discharge from each setting completed a single episode of care at the LTACH. Moreover, existing CMS policies already address CMS's stated concerns underlying this policy proposal, including the 5% readmission policy, the 3-day or less interruption of stay policy, and the post-acute transfer/discharge policy. CMS previously developed and implemented

these specific payment policies to discourage patient shifting. Under the 5% readmission policy, if the number of discharges and readmissions between an LTACH and a co-located provider exceeds 5% of the total discharges during a cost reporting period, only one LTC-DRG payment will be payable to the LTACH for all such discharges and readmissions. Under the interruption of stay policy, Medicare payments for any test, procedure, or care provided to an LTACH patient on an outpatient basis or for any inpatient treatment during an interruption of three days or less is the responsibility of the LATCH "under arrangements". Under the Medicare post-acute-care transfer policy, STACHs are reimbursed below the full DRG payment when the patient's length of stay is short relative to the geometric mean length of stay for the DRG whenever beneficiaries are discharged from selected DRGs to, among other providers, LTACHs. This policy originally applied to 10 DRGs beginning in fiscal year 1999 and was expanded to additional DRGs in FY 2004. It is very important to emphasize that 83% of DRGs applicable to STACH discharges to LTACHs are subject to the post acute transfer payment policy. The post-acute transfer payment policy was based on the belief that it was inappropriate to pay the sending hospital the full DRG payment for less than the full course of treatment. Expansion of the 25% rule is duplicative of these existing rules.

(4) This is no Evidence that Short Term Acute Care Hospitals are Discharging Patients to LTACHs "Early," Prior to Completing Episodes of Care, to Maximize Profit

There is no data to support a concern that STACHs are systematically discharging patients "early" to LTACHs prior to completion of an episode of care in order to maximize profit or obtain a full DRG payment. On the contrary, MedPAR 2005 data show that the average length of stay for acute hospital patients eventually sent to LTACHs is more than 4 days longer than the geometric mean length of stay for patients in the same DRGs (Figure 8, page 16). Among non-trach patients, the average length of stay for patients eventually sent to LTACHs is nearly twice the geometric mean length of stay for all patients in the same DRGs (Figure 9, page 17). This indicates that the more medically complex patients typically sent to LTACHs are staying in the acute hospital longer than the average patient and that acute hospitals are not systematically discharging patients to LTACHs early in order to maximize profits. The one exception to this pattern is DRGs 541/542 (patients dependent on a ventilator who also received a tracheotomy). These patients are generally discharged earlier than the acute care hospital geometric mean length of stay (Figure 7, page 15). However, as discussed more fully below, payment for nearly 70% of these patients is less than a full DRG amount because payment is adjusted by the post acute transfer policy. It is very important to note that 83% of the DRGs applicable to acute hospital discharges to LTACHs are subject to the post acute payment policy, so any concern that CMS might have about "early discharge" of patients by acute care hospitals to LTACHs is already addressed by CMS payment policy. In any event, there is no evidence from the data that "early discharge" is occurring.

(5) There is no Evidence that Short Term Acute Care Hospitals are Discharging Patients to LTACHs "Early," Prior to Completing Episodes of Care, to avoid High Cost Outlier Status

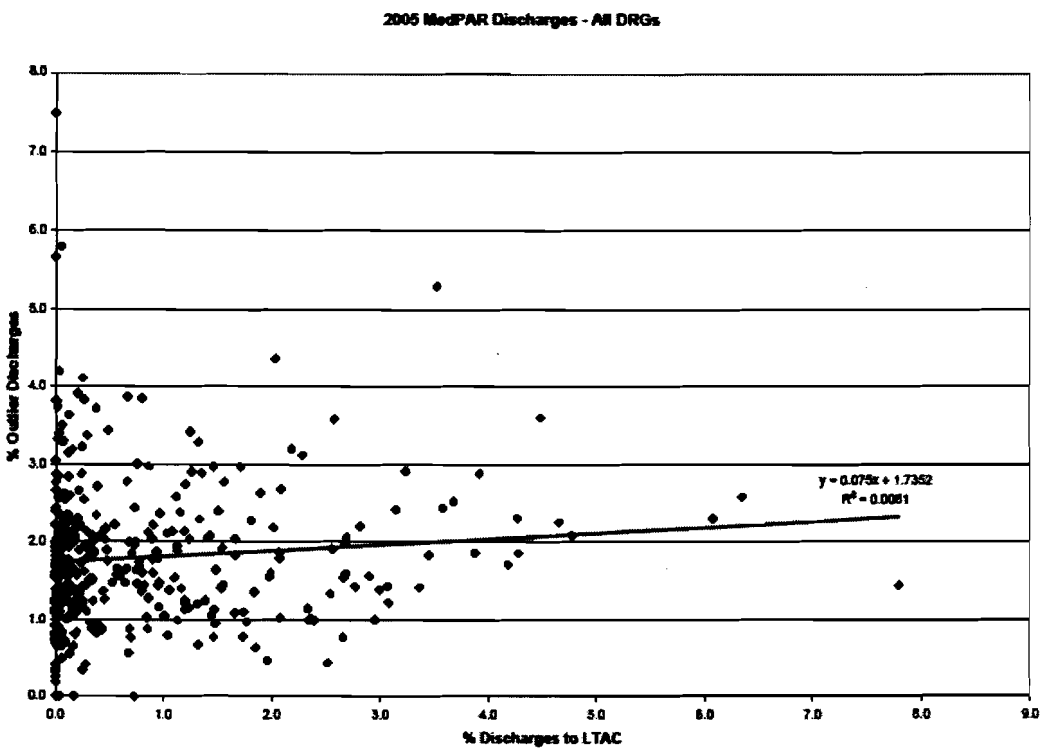
Although not specifically discussed in the rulemaking record, conversations with CMS revealed that another possible justification for the proposal to extend the 25% rule to freestanding LTACHs is the concern that STACHs may be discharging patients "early" to LTACHs, prior to completing episodes of care, to avoid high cost outlier status. CMS did not publish data to support this concern and analysis of MedPAR 2005 data shows the concern is unjustified. There is no relationship between the percent of high cost outlier cases in acute care hospitals and the percent of discharges to LTACHs. If anything, the data show the opposite, i.e., as the percentage of acute hospital discharges to LTACHs increases, the percentage of high cost outliers in acute hospitals also increases, albeit only slightly. The same pattern holds if the percentage of Medicare reimbursement spent on high cost outliers is used rather than the percentage of high cost outliers.

The following charts show the relationship between the percentage of high cost outliers in acute care hospitals and the percentage of total discharges to LTACHs in each of 385 metropolitan areas and metropolitan divisions. Using the appropriate field in MedPAR, the y-axis identifies acute hospital high cost outliers. The x-axis identifies for each acute care hospital the percentage of discharges to LTACHs. The individual data points on the graph indicate metropolitan areas with varying degrees of discharges to LTACHs. Data points further out on the x-axis indicate markets having a higher percentage of cases being discharged to LTACHs. If it were true that utilization of LTACHs is related to a decline in STACH high cost outlier cases, the chart would show a downward sloping curve. With one exception, the chart shows an upward sloping curve that disproves any notion that STACHs are discharging patients early to LTACHs.

We conducted the analysis for all DRGs, the top 10, 20, 30 and 50 DRGs with the most frequent acute hospital discharges to LTACHs, and for the highest frequency discharge to LTC-DRGs (541 and 542, ventilator-trach patients). The charts show the following:

All DRGs (Figure 1): For all DRGs, the percentage of high cost outliers in acute care hospitals actually increases slightly as the percentage of discharges to LTACHs increases. Specifically, for every 1% increase in the percentage of acute hospital discharges to LTACHs, there is a corresponding .075% increase in the percent of acute hospital high cost outlier cases. This is directly contrary to any concern that use of LTACHs lowers the percentage of high cost outliers.

Figure 1



Top 10, 20, 30 and 50 Frequency DRGs (Figures 2-5): This same pattern holds for the highest frequency DRGs among patients discharged from acute care hospitals to LTACHs. Specifically, the data show that as the percentage of discharges to LTACHs increases, there is essentially no change in the percentage of acute care cases that become high cost outliers--the graph line is flat. Again, this is directly contrary to CMS's stated concern.

Figure 2

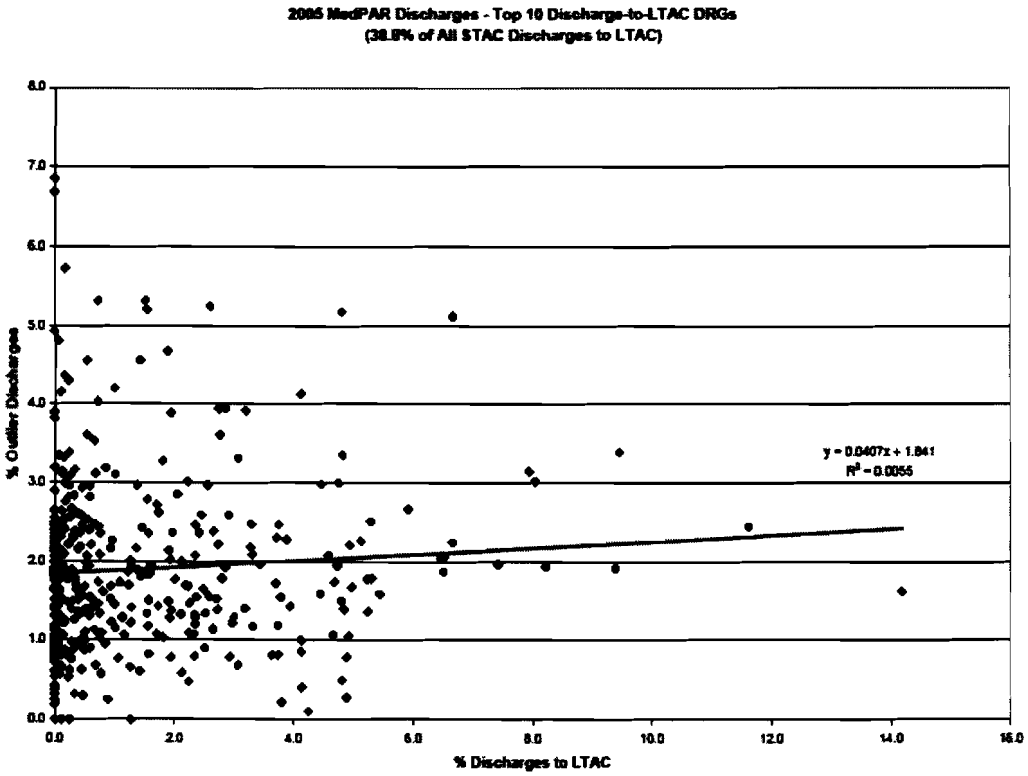


Figure 3

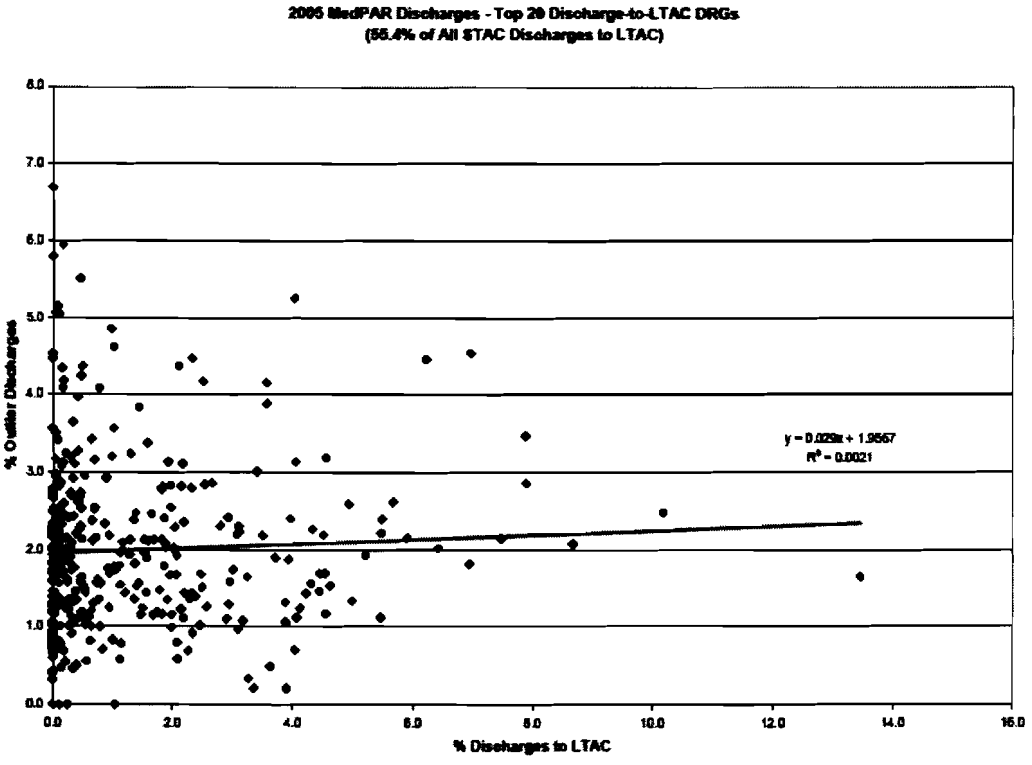


Figure 4

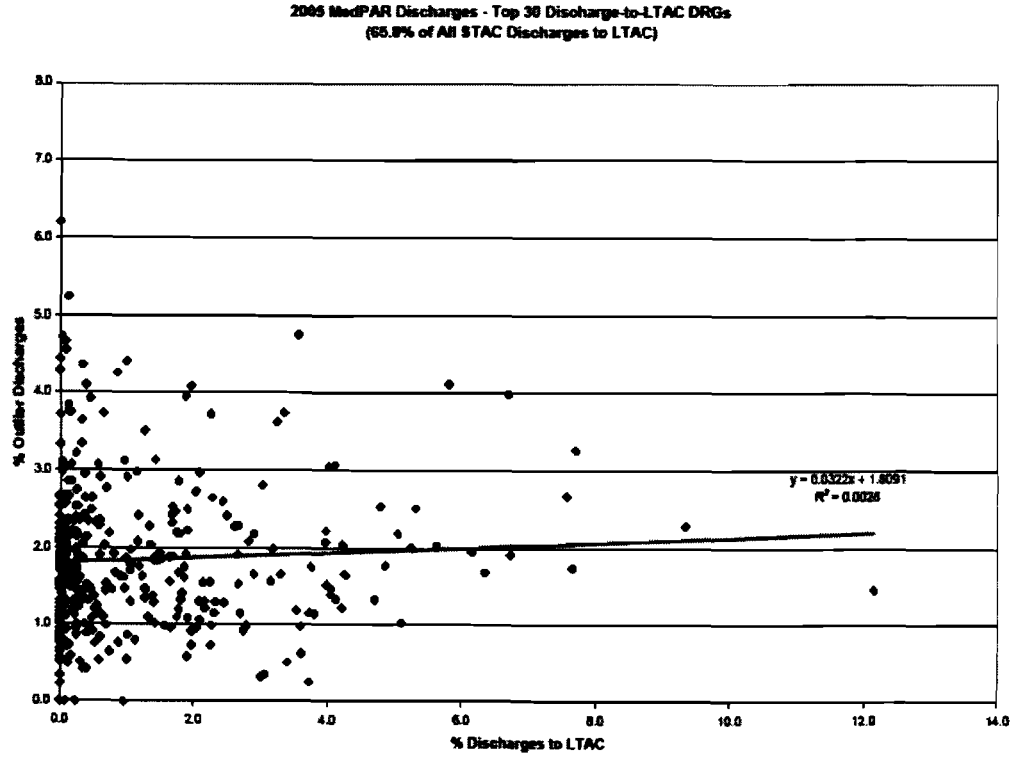
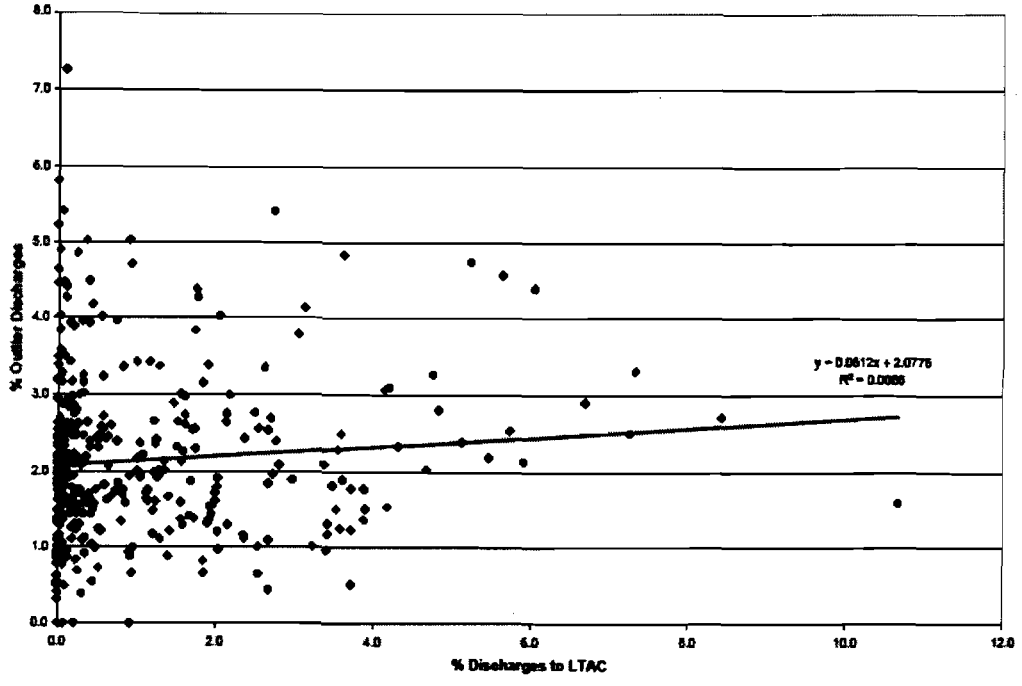
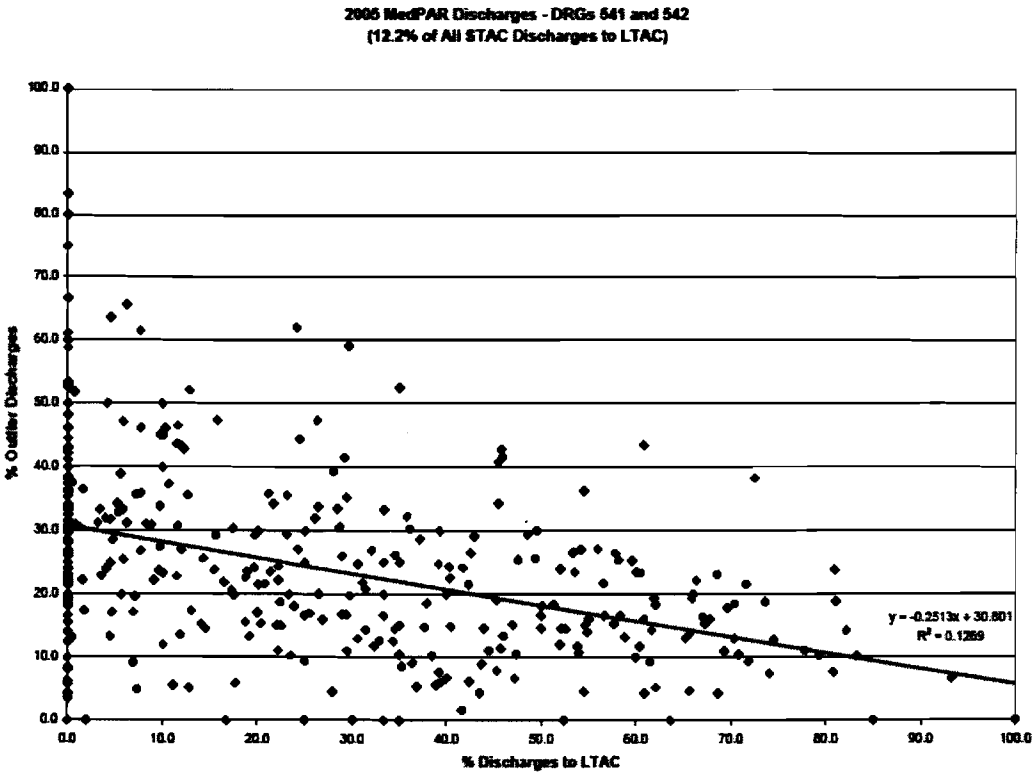


Figure 5



DRGs 541 and 542 (Figure 6): The one exception to these findings is for the most common type of patients discharged from acute hospitals to LTACHs, ventilator-dependent patients who also received a tracheotomy in the acute care hospital. For these patients the data show that the percentage of high cost outlier cases in acute care hospitals declines by less than 1% (0.25%) for every one percent increase in the percentage of cases discharged to LTACHs. In other words, the graph in Figure 6 does show a slight downward slope indicating that use of LTACHs affects somewhat the percentage of high cost outlier cases in acute care hospitals for these patients.

Figure 6

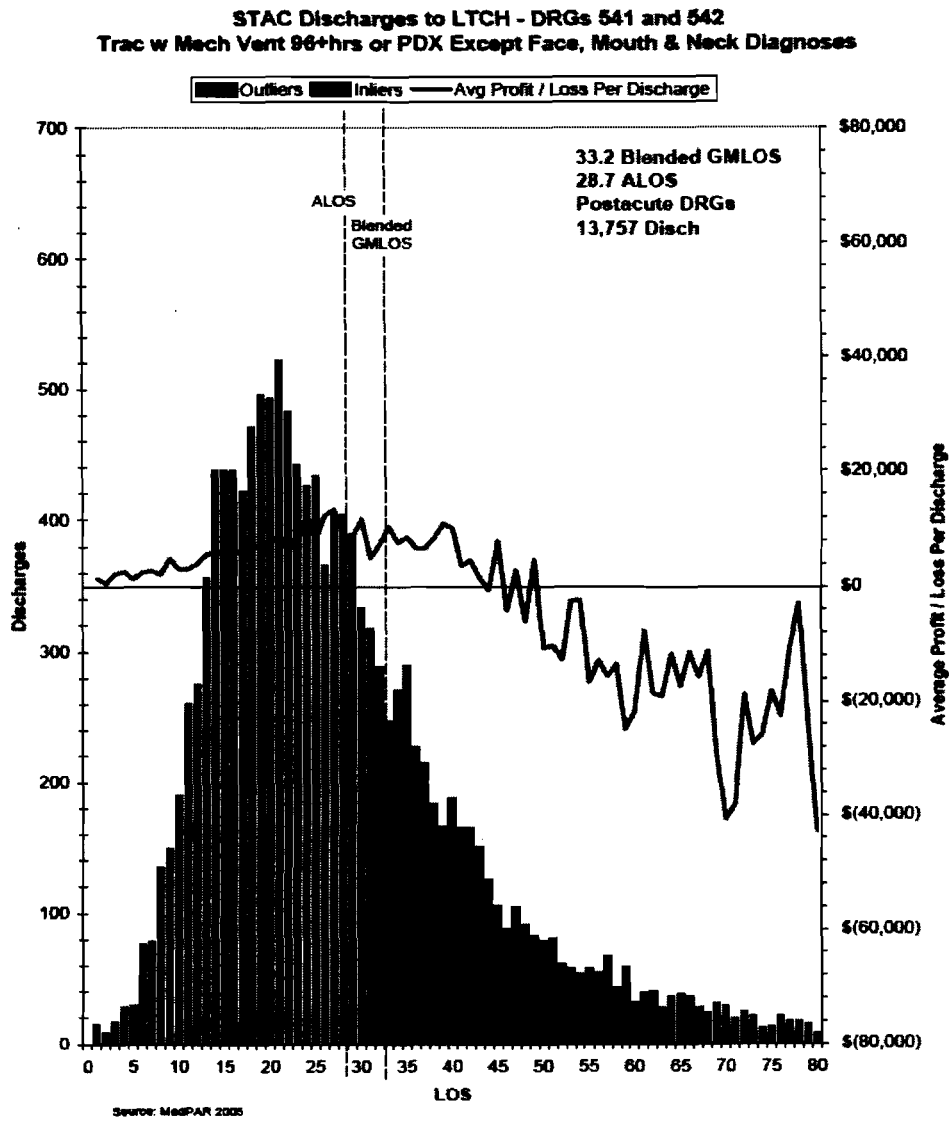


Despite the correlation indicated by the chart, this pattern does not support CMS's concern that LTACH utilization unduly increases costs to the Medicare program, for three reasons:

- First, overall, the percentage of acute hospital high cost outliers for DRG 541/542 patients discharged to LTACHs (17.2%) and comparable patients not discharged to LTACHs (20.0%) is not significantly different;

- Second, although it is obvious that trach/vent patients are discharged "earlier" when LTACHs are available (as indicated by a decline in high cost outlier percentage), the majority of these patients (68.7%) have a length of stay that is more than a day less than the geometric mean for these DRGs and therefore receive a Medicare payment reduction pursuant to the post-acute transfer policy (see Figure 7 below). In other words, the majority of trach/vent patients discharged to LTACHs are paid less than the full DRG amount because they are discharged early, so CMS actually saves some money on these patients. In addition, for trach/vent patients not discharged to LTACHs, the percentage of cases subject to the post-acute transfer policy is significantly less (49.2%), indicating that Medicare more often pays the full DRG amount for patients not sent to LTACHs.

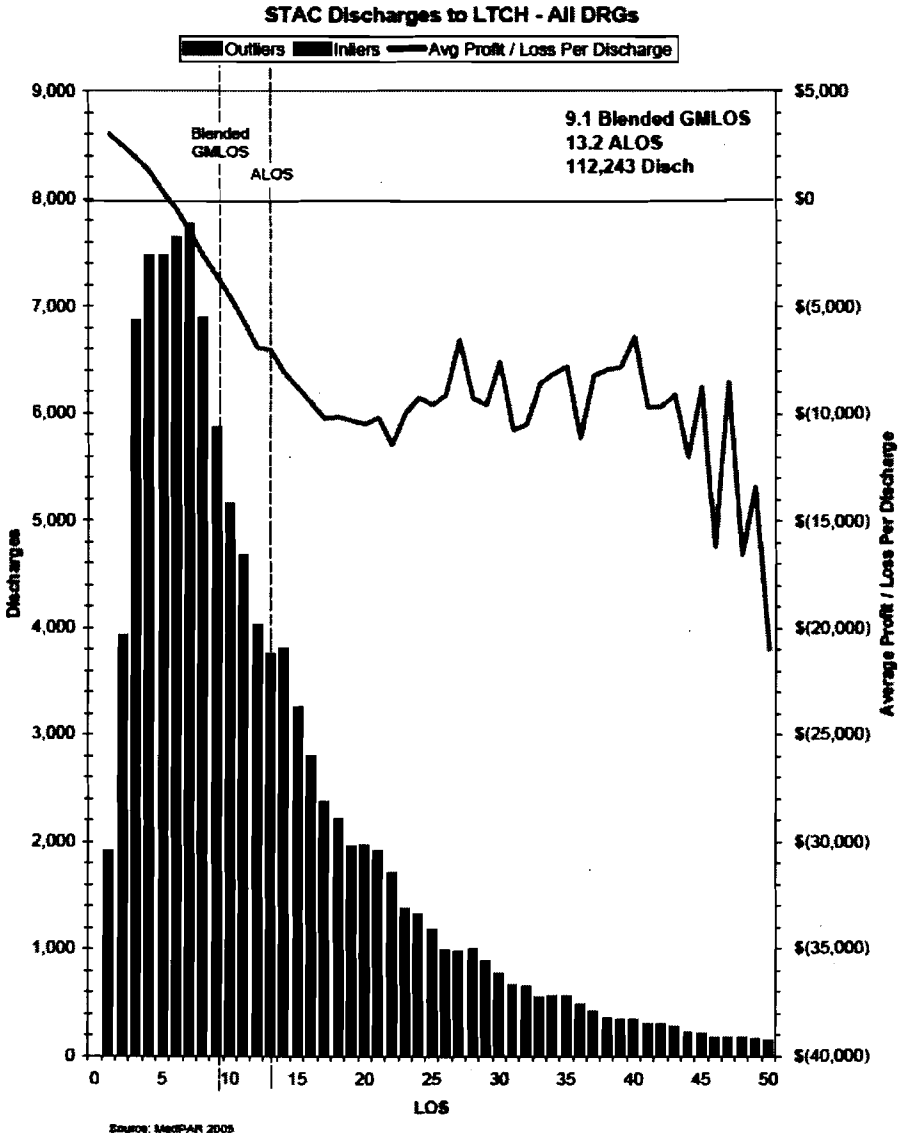
Figure 7



- Third, and equally important, both MedPAC and RTI found that Medicare's total cost for the entire episode of care (including admission to other post-acute venues and readmission to acute hospitals) for this subset of trach/vent patients is no more expensive--and in some cases can be less expensive--than comparable patients not sent to LTACHs. Accordingly, CMS should not be concerned that for this subset of patients there is a somewhat lower percentage of high cost outliers when LTACHs are used.

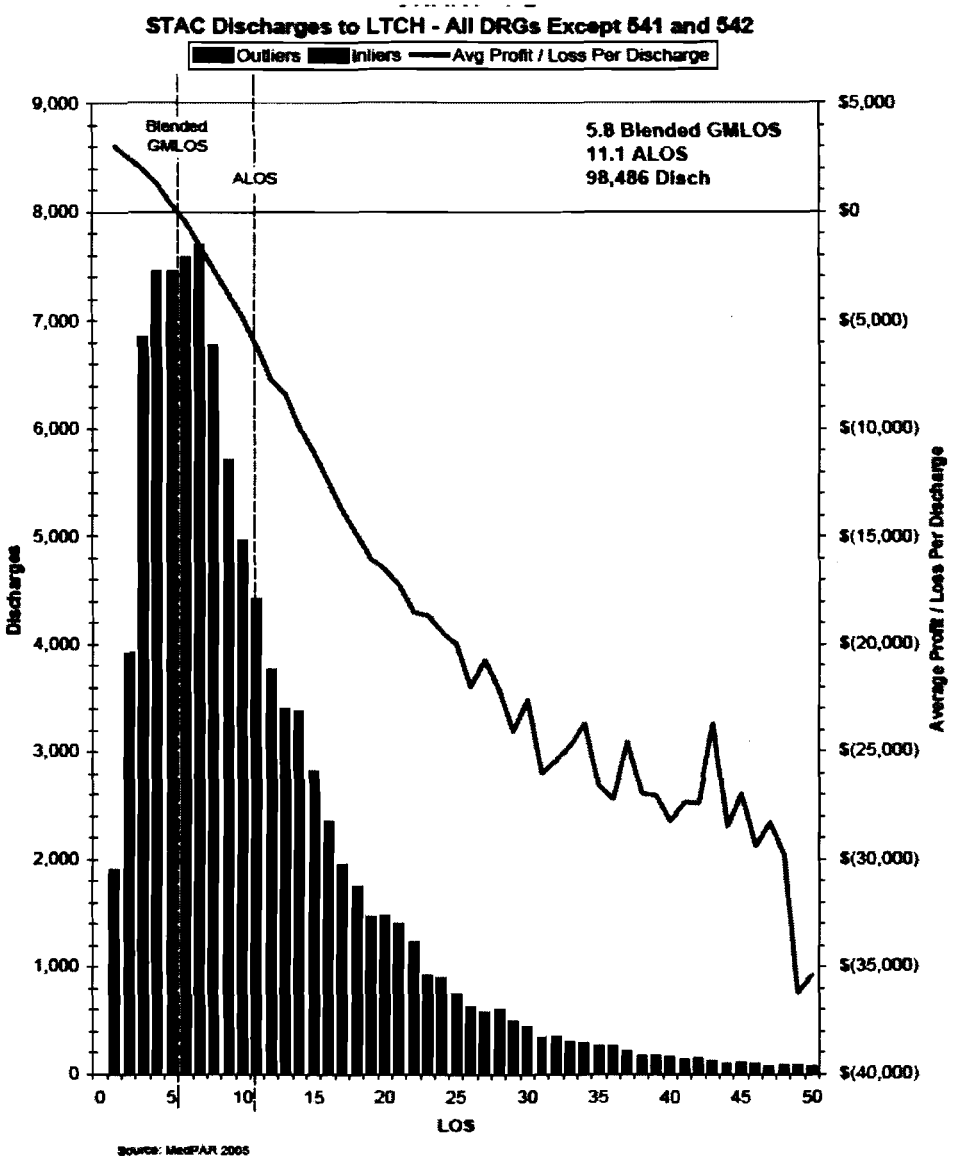
The graph in Figure 8 shows that the ALOS for acute hospital patients eventually sent to LTACHs is more than 4 days longer than the geometric mean length of stay for patients in the same DRGs.

Figure 8



The graph in Figure 9 shows that among non-trach patients, the ALOS for patients eventually sent to LTACHs is nearly twice the geometric mean length of stay for all patients in the same DRGs. This indicates that the more medically complex patients typically sent to LTACHs are staying in the acute hospital longer than the average patient and that acute hospitals are not systematically discharging patients to LTACHs early in order to maximize profits. As we discussed, the one exception to this is DRGs 541/542 where patients are generally discharged earlier than the acute care hospital geometric mean length of stay and payment is adjusted by the post acute transfer policy for nearly 70% of these patients. It is very important to note that 83% of the DRGs applicable to acute hospital discharges to LTACHs are subject to the post acute payment policy.

Figure 9



(6) Publicly Available Data Show that Medicare Is Not Paying Twice for a Single Episode of Care since there is limited overlap between DRGs and STACHs and LTACHs

For Medicare payment purposes, the "episode of care" for STACHs is defined by the DRG assigned to patients upon discharge. Thus, the only way Medicare could possibly be paying for a single episode of care is if a patient discharged from a short-term hospital with a specific DRG is assigned the same DRG when discharged from an LTACH.[2] But MedPAR data shows there is very little overlap

2 Even if the patient is assigned the same DRG it is not true, per se, they have the same episode of care because patient's characteristics and needs – and therefore the specific course of treatment – could differ significantly even within the same DRG. Specifically, Congress has authorized payments to LTACHs

between the most common DRGs assigned to patients when discharged from STACHs to LTACHs and the DRGs assigned to the same patients when discharged from LTACHs. These data rebut CMS's assumption that Medicare is paying twice for a single episode of care.

If CMS is correct in assuming that patients in STACHs discharged to LTACHs are effectively continuing the same episode of care, then the case counts for common DRGs for patients in STACHs who are sent to LTACHs would match the case counts in those DRGs for patients discharged from LTACHs. But that is not what the data show. There is no one-to-one ratio of cases for STACH patients and LTACH patients in any of the most frequent DRGs assigned to patients in STACHs who are ultimately sent to LTACHs. There are only 6 DRGs in the top 100 most frequent LTACH DRGs where the count of cases in both settings comes close to a one-to-one ratio (defined as less than a 25 case disparity). The average disparity in case counts across the two settings is 952 cases. Indeed, as shown by the data in Table 2 below, there are only 3 overlapping DRGs in the 10 most common DRGs for patients in LTACHs and for STACH patients discharged to LTACHs: 475 (Respiratory Diagnosis with Ventilator), 88 (Chronic Obstructive Pulmonary Disease), and 89 (Simple Pneumonia). Even within these 3 DRGs, the case counts are very different, which further rebuts CMS' assumption that there is a single episode of care.

Table 2

[illegible] Rank	DRG	[illegible] Description	[illegible] LTACH PPS Discharges	[illegible] Discharges	[illegible] PPS Discharge to LTACH
1	475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	16,102	4,277	4
2	271	SKIN ULCERS	6,601	1,047	27
3	87	PULMONARY EDEMA & RESPIRATORY FAILURE	6,108	1,596	16
4	79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	5,894	2,824	9
5	88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	5,414	2,630	11
6	249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	5,357	140	117
7	89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	5,263	3,766	6
8	12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	5,175	660	38
9	466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	5,034	7	334
10	462	REHABILITATION	4,903	844	32

for patients with lengths of stay, on average, greater than 25 days regardless of the DRG assigned. See 42 U.S.C. § 1395ww(d)(1)(B)(iv)(I).

The reason for the disparity in case counts is clear: patients treated in the STACH were assigned a different DRG reflecting a different episode of care than what they received when they were discharged from the LTACH.

(7) Ventilator Patient Data Show Separate Episodes of Care in the STACH and the LTACH by DRGs, and Different Patient Characteristics and Course of Treatments

Further evidence that Medicare is not paying twice for a single episode of care is established by examining DRG codes for ventilator patients, the most common LTACH patient. There are different DRGs for patients on ventilators reflecting fundamentally different patient conditions, care protocols, lengths of stay and ultimately episodes of care. Examination of data for these DRGs conclusively rebuts CMS's presumption that Medicare is paying twice for a single "episode of care" for these patients.

The most common discharge DRGs for patients discharged from STACHs to LTACHs is DRGs 541 and 542 (for patients who have had the surgical procedure for a tracheotomy in addition to being ventilator dependent). These are the most medically complex ventilator patients with an average length of stay in the acute hospital of over 35 days. These patients required a tracheotomy because it is anticipated they will be dependent upon a ventilator for prolonged periods of time. In 2005, there were 13,753 discharges from STACHs to LTACHs in DRGs 541 and 542, or 12.26% of all discharges from STACHs to LTACHs. At the same time, there were only 1,212 patients (0.89%) with DRGs 541 and 542 discharged from LTACHs.

Another DRG related to ventilators is DRG 475, assigned to patients who were dependent on a ventilator but did not receive a tracheotomy. These patients are less medically complex, have shorter lengths of stay, and most are not even dependent on a ventilator when they are discharged from the acute care hospital. It is less common for DRG 475 patients to be discharged from acute hospitals to LTACHs. In 2005 there were only 4,277 STACH patients classified into DRG 475 who were subsequently discharged to LTACHs. Yet, there were 16,102 patients discharged from LTACHs classified into DRG 475.

Differences in patient characteristics and the course of care explain the disparity in DRG frequencies across these two settings. Most of the 16,102 LTACH patients receiving ventilator support services under DRG 475 in the LTACH were placed on a ventilator along with receiving a tracheotomy in the STACH prior to being admitted to an LTACH. As a result, these patients were generally classified into DRGs 541 or 542 upon discharge from the STACH. The 16,102 patients discharged from LTACHs with vents were not classified into DRG 541 or 542 because they were already had a tracheotomy and were on both a ventilator and trach when they arrived at the LTACH. Instead, these LTACH patients are classified into DRG 475. The different course of treatments explains why the data show 13,753 STACH patients discharged to LTACHs were classified into DRG 541 or 542. Simply stated, this important subset of patients experience different episodes of care in the STACH and the LTACH, based upon different patient characteristics and different courses of treatment, as reflected in the assignment of different DRGs.

If CMS decides to finalize this policy, which we firmly object to based upon the data discussed herein, under its own rationale CMS must limit the 25% rule extension to LTACH discharges that had the same DRG upon discharge from the STACH because DRGs define the episode of care for Medicare payment purposes. CMS's justification for expanding the 25% rule is entirely inapplicable when the patient is discharged from the LTACH with a different DRG. An assignment of different DRGs at each facility reflects the different care provided in each setting and the separate episode of care experienced by the patient. CMS has offered no rationale or data explaining why the payment limit should apply to a patient that Medicare defines as experiencing a different spell of illness and receiving different treatment in a different setting. An "IPPS equivalent" payment adjustment only makes sense when the patient continues the same course of treatment from the STACH to the LTACH based on the DRGs at

discharge. In the case of the LTACH DRG 475 patient, the LTACH should be paid at a rate comparable to IPPS DRGs 541/542, reflecting the fact that the acute "episode of care" was for a patient on a ventilator as well as receiving a tracheotomy. If CMS refuses to recognize the differences in care provided by LTACHs, then CMS must, at minimum, limit the application of this policy to those instances where the concern being addressed is even plausible and, if the case is paid at the IPPS equivalent, the payment should be at a rate comparable to the IPPS DRG.

(8) Because There Are No Data to Support CMS's Assumptions, It Is Inappropriate for CMS to Extend the 25% Rule to Freestanding LTACHs

For all the above reasons, the assumptions supporting this proposal are not based on the data and in fact are refuted by available data. Accordingly, it is inappropriate for CMS to extend the 25% rule to freestanding LTACHs because it would not pass the "rational basis" test under the courts' interpretation of the Administrative Procedure Act ("APA").

The APA governs judicial review of agency actions. When the validity of an agency regulation is challenged, the APA authorizes the reviewing court to "decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of an agency action."[3] An agency's action may be set aside it if is, among other things, arbitrary, capricious an abuse of discretion or otherwise not in accordance with law.[4] The seminal case on the traditional standard for arbitrary and capricious review is Motor Vehicle Mfrs. Ass'n v. State Farm Mutual Auto. Ins. Co.[5] After concluding that it would not accept the agency "counsel's *post hoc* rationalizations for [the] agency action," the Court held that the NHSTA failed to supply the requisite reasoned analysis "to enable [the Court] to conclude that the rescission was the product of reasoned decisionmaking."[6] Without a clear rational basis for an agency action, courts have followed State Farm to strike down regulations. See Shays v. Federal Election Comm'n, 337 F. Supp.2d 28, 92 (D.D.C. 2004), aff'd 414 F.3d 76 (D.C. Cir. 2005) (concluding that the Commission had not "articulated an explanation for its decision that demonstrates its reliance on a variety of relevant factors and represents a reasonable accommodation in light of the facts before the agency."); Athens Community Hospital v. Shalala, 21 F. 3d. 1176 (D.C. Cir. 1994) (finding that the Secretary failed to provide a rationale to support her rule).

c. CMS Has Not Provided Evidence to Support the Allegation that LTACHs Are Evading the Current 25% Rule by Establishing Non-Co-Located Freestanding LTACHs

In the preamble to the proposed rule, CMS suggests that LTACHs may be evading the existing 25% rule by establishing non-co-located freestanding LTACHs in close proximity to a referring hospital. To date, CMS has provided no evidence that LTACHs are relocating for the sole purpose of avoiding the existing 25% rule. Before CMS adopts new payment policies for non-co-located LTACHs, CMS must provide evidence of the problem it seeks to address by making data (or findings) available to the public for review and comment. Expanding the 25% rule is premature, unless CMS can support this policy with verifiable evidence of the problem and be reasonably assured that the action taken in turn does not negatively impact the quality of care provided to Medicare beneficiaries or the availability of such care. It is clear that CMS is not in a position to make further policy changes pertaining to freestanding

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[3] 5 U.S.C.S. § 706.

[4] Id. § 706(2)(A).

[5] 463 U.S. 29 (1983).

[6] Id. at 52 and 57.

LTACHs 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.

In proposing to expand the 25% rule, CMS contends that the existing payment limitation applied to HIHs and satellites has failed to slow growth in the number of new LTACHs. CMS's own data shows that this presumption is false. According to the December 2006 CMS Provider of Service file, there was a net reduction of one LTACH in 2006: nine LTACHs were decertified (eight of which were HIHs), and eight new LTACHs were certified (six of which were freestanding LTACHs). Comparatively, there was a net increase of twenty-eight LTACHs in 2005, half of which occurred in the first quarter of 2005. This change illustrates a dramatic decrease in the number of new LTACHs. Developing a new hospital requires extensive planning and time. Accordingly, the growth in the total number of LTACHs in 2005 likely reflects projects that were initiated in 2003 and 2004, prior to adoption and implementation of the existing 25% rule. The recent reduction in the growth of LTACHs reflects the implementation of the 25% rule, as well as the anticipated effect of Medicare payment policies. Given that the 25% rule will not take full effect until 2008, it is reasonable to expect that more HIHs will voluntarily decertify as LTACHs after the transition period ends. CMS has previously asserted that growth in the number of LTACHs was attributed to the establishment and implementation of LTACH PPS. 69 Fed. Reg. 49,195. Assuming this assertion is true; CMS has not allowed enough time to pass to determine if changes to the LTACH PPS system have a corresponding impact on the growth of new LTACHs. As noted above, full implementation of the existing 25% rule does not occur until the first cost reporting period beginning on or after October 1, 2007.

As part of an extensive discussion in the preamble, CMS alleges that LTACHs are evading compliance with the 25% rule by engaging in arrangements that are structured to be outside the scope of the 25% rule. The existing 25% rule was adopted in light of concern that LTACHs located in the same building or on the same campus of a short-term STACH would be acting as a unit of the co-located hospital. LTACHs not located in the same building or on the same campus as another hospital are not subject to the 25% rule. Simply because an LTACH engages in an arrangement that is outside the scope of the existing rule does not mean that the particular LTACH is "evading" compliance. By definition, freestanding LTACHs 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 LTACH discharges that were admitted from a single hospital referral source – by citing the absence of statutory authority for LTACH units. We believe that this theory exceeds any reasonable interpretation of the statute.

d. The Proposed Rule Will Result in a Number of Unintended Consequences that Weigh Against Its Implementation

(1) The Proposed Rule Will Have a Disparate Impact on LTACHs in Areas With Fewer Referral Sources

An immediate impact of the proposed rule, if finalized, will be experienced in markets with less than four STACHs or in markets where a single STACH specializing in treating medically complex patients accounts for a large percentage of Medicare LTACH discharges. In these markets, it is likely that medically complex patients will not be evenly distributed and the LTACH's patient census will be affected by this proposed policy. The usual dynamic is for patients who later require LTACH care to cluster at a tertiary care center. A patient quota system, like the one proposed, applied evenly to all STACHs in the market will prevent the LTACHs in that market from operating as effectively as MedPAC and RTI envision since *referrals will be most restricted from the STACH whose caseload is most in need of LTACH services.* Rather than reward the referral and discharge relationships between STACHs and LTACHs for improving the patient continuum of care, CMS would penalize these relationships based upon false assumptions.

The effect of this penalty will be felt the most in underserved areas. A safety net of 50% for LTACHs in underserved areas is wholly inadequate. Some of these LTACHs only have one STACH referral source. In these areas, it is *irrefutable* that a 50% rule will limit access to patient care, restrict patient choice, and trump medical decision-making. Patients in the 51st percentile will not be merely limited in their choice of provider, LTACH services will, on a practical level, be inaccessible all together. Application of the admission threshold to LTACHs in urban-single, MSA dominant and rural areas will have a compounding effect, regardless of the higher percentage that may be admitted before the payment limitation applies. These underserved areas have fewer STACHs and LTACHs and patients who must travel greater distances to reach local health care providers. Expansion of the payment limitation in underserved areas will cause an undetermined number of patients, who cause the sole LTACH to exceed the admission threshold on referrals from the sole STACH, to be denied care in the most appropriate setting. This significant impact on patient care will occur without credible evidence of the problem the policy seeks to cure.

Thus, this proposed policy creates a payment penalty for underserved areas that will have the anomalous effect of making compliance easier in geographic areas where there is already a concentration of LTACHs or could sustain a greater concentration of LTACHs. Similarly, LTACHs located in more densely populated areas will generally fare better than LTACHs located in rural and underserved areas because there will be more STACHs to refer patients.

(2) This Proposal Greatly Restricts Consumer Choice, Patient Access to Care, and Interferes with Medical Decision-Making

As mentioned above, the expansion of the 25% rule to non-co-located LTACHs and grandfathered HIHs will impact the ability of all LTACHs to treat patients admitted from a single hospital regardless of the appropriateness of the services offered by a particular LTACH to a particular patient. The proposed rule does nothing to improve patient care. In fact, the proposal will result in diminished access to quality care for patients requiring LTACH services. Patients who require a transfer from a hospital that has already transferred a number of patients to the same LTACH will be required to find an alternate provider that may not be located in the same community as the patient or the patient's family. An arbitrary percentage (25% or otherwise) on the number of LTACH referrals who will be reasonably reimbursed under the LTACH PPS should not trump the beneficiary's choice to be treated in an LTACH, based upon a physician's medical judgment that the beneficiary is appropriate for LTACH care and would benefit from that care.

Such a result could undermine physicians' discretion to determine what is in the best interest of patients in terms of post-hospital care in violation of section § 1801 of the SSA (42 U.S.C. 1395)("Nothing in this title shall be construed to authorize any Federal Officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided . . . ."). The American Medical Association's ("AMA's") policy statements regarding the development of practice parameters and level of care guidelines emphasize its position that such guidance must not interfere with a physician's autonomy in making medical care decisions. See AMA Policy H-285.920 ("level of care guidelines must allow for appropriate physician autonomy in making responsible medical decisions"); AMA Policy H-410.970 ("Physicians must retain autonomy to vary from practice parameters . . . in order to provide the quality of care that meets the individual needs of their patients."). Therefore, the arbitrary nature of the proposed extension of the 25% rule is highly problematic, despite that CMS technically classifies it is a payment policy rather than as a policy that affects the practice of medicine.

Such a result could also violate section 1802(a) of the Social Security Act ("SSA")(42 U.S.C. 1395a(a)) which provides that "[a]ny [Medicare beneficiary] may obtain health services from any institution, agency, or person qualified to participate [in Medicare] if such institution, agency, or person undertakes to provide him such services.") Because patient choice is such a basic tenet of not only federal health care programs but the health care system in this country as a whole, CMS should

reconsider any policies that would interfere with patients being admitted to the LTACH of their choice upon discharge from an STACH.

CMS itself has incorporated the principle of patient choice throughout its regulations and sub-regulatory guidance. See 42 C.F.R. § 482.43 (including as a condition of participation in Medicare for hospitals that they, "as part of the discharge planning process, must inform the patient or the patient's family of their freedom to choose among participating Medicare providers of post-hospital care services and must, when possible respect patient and family preferences when they are expressed."); CMS, Your Medicare Rights and Protections (CMS Pub. No. 10112) ("[I]f you are in the Original Medicare Plan, you have the following rights and protections: 1. Access to doctors, specialists (including women's health specialists), and hospitals. You can see any doctor or specialist, or go to Medicare-certified hospitals that participate in Medicare.") Moreover, the Advisory Commission on Consumer Protection and Quality in the Health Care Industry, which published a "Consumer Bill of Rights and Responsibilities" states that "[c]onsumers have the right to a choice of health care providers that is sufficient to ensure access to appropriate high-quality health care." Advisory Commission on Consumer Protection and Quality in the Health Care Industry, Consumer Bill of Rights and Responsibilities, (Nov. 1997). Contrary to CMS's own principles, this policy would restrict patient access to the care and provider of their choice and inappropriately interfere with the medical judgment of the patient's attending physician that an LTACH is the most appropriate care setting.

This policy also is discriminatory against patients in the 26th percentile and higher. Except for consistency with the existing 25% rule, CMS offers no explanation why a 25% limitation is proposed for freestanding LTACHs versus another percentage. While the selection of a 25% threshold may be an arbitrary percentage or administratively simple from CMS's perspective, the rule has very real implications for patients in the 26th percentile and higher. Patients in the 26th percentile will have fewer options for health care services for no other reason than the fact that their episode of illness commenced later in the cost reporting period of the preferred LTACH.

We believe that these are among the unintended consequences of this policy proposal.

e. The Proposed Rule Does Not Appropriately Target Cases that Are Likely the Result of Inappropriate Admissions

CMS should establish patient and facility level criteria for LTACHs to better define the appropriate patient setting and medical conditions required for admission, rather than draw questionable assumptions about the appropriateness of admissions from a limited set of data. LTACHs already use patient screening instruments to determine the medically complex patients that are appropriate for LTACH care. This is one of a number of defined facility and patient criteria that have been proposed by the United States House of Representatives (H.R. 562) and the Senate (S. 338) for new LTACH certification criteria that would better address CMS's stated concerns in this area. Instead of taking a similarly targeted approach, the proposed policy imposes an arbitrary limitation on payment.

LTACHs admit patients only after applying an objective and rigorous set of admissions screening criteria. To confirm this, Medicare QIOs conduct post-admission reviews of LTACH patients to ensure that the admission was medically necessary. At CMS's direction, QIOs have been reviewing a sample of LTACH cases for admission appropriateness. Data available to CMS clearly show an immaterial number of LTACH claims denied as the result of QIO reviews. The QIO review data does not support CMS's assumption that cases were inappropriately admitted to LTACHs as a result of LTACHs acting as extension sites or units of STACHs or patients receiving less than a full episode of care at the STACH. On the contrary, QIOs are overwhelmingly finding that LTACH patients have appropriately been admitted and treated in LTACHs.

f. The Proposed Rule Provides No Mechanism for LTACHs to Monitor Compliance with the 25% Rule

CMS has failed to consider the practical considerations of how LTACHs will comply with the proposed rule. For example, there is no mechanism for STACHs to share outlier data with LTACHs in order to self-monitor compliance with the 25% rule. While the rule requires that LTACHs exclude from the 25% calculation all patients "on whose behalf a Medicare outlier payment was made to the referring hospital," LTACHs have no practical means of determining which patients were outliers at the STACH. This requirement presents a significant challenge to freestanding LTACHs. There is no standard communication from the referring hospital that provides the data necessary for the LTACH to make such a determination. It is up to the LTACH to establish a relationship with the referral source. As a result, the LTACH is totally dependent upon the accuracy of the data supplied by the referring hospital. It is not unusual for the referring hospital to be unfamiliar with the payment status of the patient at the time of admission to the LTACH, or for the referring hospital to submit final bills on its discharged patient well after the admission at the LTACH. Also, if changes occur to the Medicare bill as a result of a review by CMS or the fiscal intermediary, the referring hospital most likely would not contact the LTACH about a change in patient status. Currently there is nothing that compels a referring hospital to cooperate with the LTACH in this regard.

While the existing 25% rule excludes outliers in the calculation of the payment limitation threshold, relationships between co-located hospitals is significantly different than the typical interactions of non-co-located hospitals. A LTACH HIH has greater access to staff of the co-located hospital who can more easily provide and confirm outlier data. By its own rules, CMS acknowledges the difference in relationships between co-located hospitals and non-co-located hospitals. Freestanding LTACHs typically do not have regular interaction with non-co-located hospitals. Furthermore, patient medical records and other information conveyed to the LTACH as part of a patient's admission will not describe whether a Medicare outlier payment was made to the referring hospital.

As the rule has been proposed, it will be extremely difficult for freestanding LTACHs to monitor compliance with the 25% admission limit during any single fiscal year. Without adequate assurance that it has not exceeded the admission threshold, an LTACH is exposed to an unquantifiable degree of risk of being assessed an overpayment at the end of each cost reporting year. In the August 11, 2004 final rule establishing the 25% rule, CMS stated a clear interest in adopting a payment limitation on admissions from co-located hospitals that "fiscal intermediaries would be able to evaluate annually in an efficient manner without the involvement of corporate attorneys and a yearly reevaluation of corporate documents and transactions." 69 Fed. Reg. 4,9194. While fiscal intermediaries may be able to efficiently determine compliance with the proposed rule long after the end of an LTACH's cost reporting year, the same is not true for LTACHs themselves. Furthermore, the financial implications of noncompliance make it essential that LTACHs can effectively monitor compliance on an ongoing and timely basis. As the rule has been proposed, LTACHs will face an unacceptable degree of uncertainty.

CMS has yet to define the process that will be used to monitor an LTACH's compliance with the 25% limit. There is not a definitive document or set of documents that LTACHs are instructed to rely upon in self-monitoring towards this goal, neither is there any guidance provided by CMS as to the manner in which they will gauge a hospital's compliance.

There is a limited exception to the proposed 25% rule for LTACHs that are in an "MSA-dominant" hospital. An MSA-dominant hospital is a facility that discharges more than 25% of the patients in the MSA in which it is located. This exception allows the LTACH to accept the percentage of patients that the MSA dominant hospital is responsible for discharging in that MSA, but no more than 50%. This presents an exceptional monitoring challenge to the LTACH. In measuring its ongoing compliance with this restriction, the LTACH would need to know the percentage of discharges at the MSA dominant hospital on an ongoing basis. During its cost reporting year, an LTACH has no mechanism for determining what percentage of discharges the MSA dominant hospital is responsible for in the MSA. As drafted, the proposed regulation does not describe any method for computing this percentage, or define how CMS will monitor compliance with the percentage. Both should be clear to the LTACHs in order to eliminate confusion and financial risks.

This proposed regulation also offers a transition period. The first stage of the transition period, cost reports beginning on or after July 1, 2007 and before October 1, 2007, will limit LTACH admissions from the referral to the lesser of 50% or the Medicare discharges that were admitted from the referring hospital during the 2005 cost reporting period. While we object to the brevity of the proposed transition period, we also request that CMS clarify the meaning of the phrase "FY 2005 cost reporting period" as used in section 412.536(f)(2) of the proposed rule. We believe CMS is referring to cost reports that *end* sometime during the federal fiscal year that runs October 1, 2004 through September 30, 2005. We ask for confirmation that CMS is not suggesting a definition that "FY 2005 cost reporting period" is for cost reports that *begin* sometime during the federal fiscal year that runs October 1, 2004 through September 30, 2005.

g. Grandfathered LTACHs Have Relied Upon a Consistent Series of Public Statements by CMS that It Would Not Apply HIH Policies to Them

CMS correctly did not apply the HIH and satellite 25% rule to grandfathered LTACHs when the existing 25% rule was finalized. CMS has not provided data concerning these LTACHs that would support revoking their grandfathered status with regard to this policy.

In 1997, HCFA promulgated the grandfathering provision to the HIH regulation at 42 C.F.R. § 412.22(f). This regulation was a direct response to legislation from Congress (Section 4417 of Public Law 105-33) that a hospital excluded from the inpatient hospital PPS ("IPPS") as an LTACH on or before September 30, 1995 is not subject to the HIH rules. In the FY 1998 IPPS update released on August 29, 1997, HCFA said that it was discarding its original proposal to limit grandfathered status to state-owned HIHs as a result of the legislation. HCFA also stated in this final rule that it would apply grandfathered status to all HIHs, not just LTACHs, that were exempt from IPPS on or before September 30, 1995.

When LTACH PPS was adopted in 2002, CMS responded to a question from a commenter asking how LTACH HIHs previously grandfathered under Section 412.22(f) would be affected by the implementation of LTACH PPS. CMS responded:

> We interpret Section 4417 of the BBA, codified as Section 1886(d)(1)(B) of the Act and implemented under in Section 412.22(f), to permit existing LTCHs that were designated LTCHs on or before September 30, 1995, and were co-located with acute care hospitals as hospitals within hospitals, to be exempt from compliance with Section 412.22(e) concerning the ownership and control requirements for hospital within hospital status without losing their status as hospitals excluded from the acute hospital inpatient prospective payment system. The 'grandfathered' status conferred by the statute, which allowed these particular LTCHs to retain their pre-existing relationships with their host hospitals, will be unaffected by the implementation of the prospective payment system for LTCHs.

67 Fed.Reg. 55954 at 55969 (August 30, 2002).

In the August 1, 2003 IPPS update final rule for FY 2003 (68 Fed. Reg. 45,346, 45,463), CMS discussed the intent behind the original grandfathering provision and the extended compliance date of September 30, 2003. CMS then stated:

> In the May 19, 2003 proposed rule, we proposed to revise §412.22(f) to specify that, effective with cost reporting periods beginning on or after October 1, 2003, a hospital operating as a hospital-within-a-hospital on or before September 30, 1995, is exempt from the criteria in §412.22(e)(1) through (e)(5) only if the hospital-within-a-hospital continues to operate under the same terms and conditions in effect as of September 30, 1995. The intent of the grandfathering provision was to ensure that hospitals that had

been in existence prior to the effective date of our hospital-within-hospital requirements should not be adversely affected by those requirements. To the extent hospitals were already operating as hospitals-within-hospitals without meeting those requirements, we believe it is appropriate to limit the grandfathering provision to those hospitals that continue to operate in the same manner as they had operated prior to the effective date of those rules. However, if a hospital changes the way it operates (for example, adds more beds) subsequent to the effective date of the new rules, it should no longer receive the benefit of the grandfathering provision.

[...]

Comment: Several commenters disagreed with our proposal to require grandfathered hospitals-within-hospitals to continue to operate under the same terms and conditions that were in place on September 30, 1995 (for example, adding beds). These commenters believed that the adoption of this proposal could result in a decertification of a number of LTCHs, thus depriving Medicare beneficiaries of specialized services and unique programs. They asserted that CMS is requiring these grandfathered hospitals-within-hospitals to either reverse their previously approved changes or lose their certification, which would retroactively reverse prior governmental approvals of LTCH changes. The commenters further asserted that there is no good reason to treat these hospitals any differently from other providers participating in the Medicare program, a practice that the commenters believed would result in inequitable treatment of patients as well as employees. Furthermore, the commenters expressed concern that the proposed effective date timeframe for implementation (that is, 60 days) is too short for purposes of implementing this proposed change because it would not allow adequate time for providers to undo previous changes.

Response: We have reviewed the commenters' concerns with regard to our proposal to require "grandfathered" hospitals-within-hospitals to continue to operate under the same terms and conditions that were in place on September 30, 1995. We understand the commenters' concern that adoption of this change as proposed could adversely impact some grandfathered hospitals-within-hospitals that, over the years, have made changes to the terms and conditions under which they operate.

After careful consideration of the comments, we have decided to revise §412.22(f) to state that if a hospital-within-a-hospital was excluded from the IPPS under the provisions of §412.22(f) on or before September 30, 1995, and at that time occupied space in a building also used by another hospital or in one or more buildings located on the same campus as buildings used by another hospital, the provisions of §412.22(e) do not apply to the hospital as long as the hospital meets either of two conditions: First, under §412.22(f)(1), the hospital continues to operate under the same terms and conditions, including the number of beds and square footage considered to be part of the hospital for purposes of Medicare participation and payment, in effect on September 30, 1995. Second, under §412.22(f)(2) a hospital that changed the terms and conditions under which it operates after September 30, 1995 but before October 1, 2003, may continue in its grandfathered status if it continues to operate under the same terms and conditions, including the number of beds and square footage considered to be part of the hospital for purposes of Medicare participation and payment, in effect on September 30, 2003. The second condition was added in recognition of commenters who suggested that hospitals be held harmless for past changes in their terms and conditions of operation. We note that any changes occurring on or after October 1, 2003, including changes in number of beds or square footage, could lead to a loss of grandfathered status.

> We want to reiterate that, in establishing grandfathering provisions, our general intent has been to protect existing hospitals from the potentially adverse impact of recent, more specific regulations that we now believe to be essential to the goals of the Medicare program. However, a hospital that continues to be excluded from the IPPS through grandfathered status may wish to alter the terms and conditions that were in effect either on September 30, 1995, or after October 1, 2003, as provided in revised §412.22(h). In that circumstance, in order to continue being paid as a hospital excluded from the IPPS, the hospital would need to comply with the general hospital-within-a-hospital requirements set forth in §412.22(e).
>
> We plan to review the issue of whether further revisions to this regulation should be made to allow more changes in operation by grandfathered hospital-within-hospitals, and welcome specific suggestions on this issue.

68 Fed.Reg. 45346, at 45463 (August 1, 2003).

One year later, in the IPPS FY 2005 final rule, CMS again recited the entire history of the Congressionally mandated grandfathering provision and reiterated anew that LTACH HIHs grandfathered under Section 412.22(f) are exempt from all requirements under Section 412.22(e)(5), including (but not limited to) the "75/25" test which otherwise would require an LTACH HIH to admit no more than 25% (or other applicable percentage) of its patients from its host hospital. This was an important reiteration and restatement by CMS since in the FY 2005 IPPS Rule, CMS also announced an almost complete restructuring of LTACH HIH reimbursement requirements whereby the "75/25" Rule (referred to in these comments as the "25% Rule") was recodified from Section 412.22(e)(5) to Section 412.534 and recharacterized as a special payment provision applicable to LTACH HIHs. Nevertheless, in recodifying and restating the "75/25" Rule applicable to LTACH HIH admissions from their hosts and payment therefor, CMS continued to acknowledge that based on Congressional intent, and subsequent regulatory codification, LTACH HIHs that had been grandfathered under Section 412.22(f) would continue to be exempt from this "75/25" requirement applicable to other LTACH HIHs.

Merely because CMS chose to remove the 75/25 Rule from Section 412.22(e)(5) as it applies only to LTACHs, and then recodify and restate such rule as a payment limitation in Section 412.534, does not give CMS the right to evade the Congressional mandate and prior regulatory codification of grandfathering for LTACH HIHs that were excluded from the IPPS on or before September 30, 1995. It is absurd to give credence to CMS' suggestion that even though previously grandfathered LTACH HIHs were exempt from the 75/25 Rule when codified in one section, such facilities are no longer exempt from the effect of that rule when the rule is re-codified in another section.

Moreover, it is simply not credible to accept CMS' explanation that this new restatement or re-codification is somehow a different type of rule. It is not. If a LTACH HIH failed to meet the performance of basic functions 75/25 test in Section 412.22(e)(5), the penalty was a loss of certification as an excluded long-term care hospital, and the cases treated at the LTACH HIH would then be subject to IPPS reimbursement. Similarly, if an LTACH HIH fails to meet the 75/25 (the 25% Rule) limitation under Section 412.534, the result is little or no different; the LTACH HIH will be reimbursed at IPPS rates for all patients in excess of the 25% threshold. CMS' attempted sleight-of-hand and evasion of the Congressional mandate for grandfathering of these facilities is unsupported under any notion of law and fair play. CMS should immediately rescind its proposed regulatory end run.

More recently, CMS talked about grandfathered HIHs not being permitted "to alter their operations from the 'snapshot in time' taken when they were grandfathered and thus benefit even more from this status." CMS added that that grandfathered facilities received a benefit not enjoyed by nongrandfathered facilities – they are free from compliance with the "separateness and control" regulations – and should not be allowed to realize additional economic advantages by expansion that would increase their Medicare payments by virtue of their grandfathered status. See 71 Fed. Reg.

24,125-26. However, in the recent IPPS final rule (71 Fed. Reg. 47,870), CMS amended the grandfathering provisions in the HIH rule to clarify that CMS is primarily concerned with beds used for inpatient services, not the number or nature of services provided by a hospital that meets the HIH definition. The grandfathering provision for HIHs originally specified that changes in the number of beds or square footage would subject the hospital to a loss of its grandfathered status. As amended, the regulation allows for a decrease in bed number at any time, or an increase in bed number up to a previously reduced bed count, without affecting grandfathered status. Again, CMS stated "We believe this policy is consistent with our stated intent to allow hospitals that were in existence prior to the implementation of the HIH or the satellite rules to continue to operate under the same terms and conditions they had operated under at the time those provisions were implemented."

When CMS finalized the current 25% rule, it chose not to apply that policy to grandfathered LTACHs because of the historical protected status of these providers. Because CMS has not stated a rational basis for removing the protected status of these LTACHs, the proposed policy should not be applied to grandfathered LTACHs. This reversal of policy is unsupported by reasonable argument and unjustified in view of Congress' initial recommendation to the Secretary that a grandfathered class of LTACH facilities be established.

h. If CMS Chooses to Adopt the Proposed Rule, Existing Freestanding LTACHs and Freestanding LTACHs Under Development Should Be Afforded Grandfathered Status and Exempt from the 25% Rule

Application of the payment limitation threshold to existing and under-development LTACHs will have a substantial negative impact on the ability of existing LTACHs to continue to provide care to Medicare beneficiaries requiring LTACH-level services. Existing LTACHs were developed to comply with the rules governing LTACH PPS at the time they were certified and could not have predicted that CMS would so dramatically alter the payment system as to limit payment under LTACH PPS to no more than 25% of the facility's patients who are admitted from one STACH. By continuing to alter the rules governing LTACH PPS, CMS creates immeasurable degree of uncertainty among providers that ultimately results in increased costs and inefficiency in providing Medicare services.

Some existing LTACHs were developed in communities where a large STACH system necessarily refers to the LTACH more than 25% of the LTACHs admissions. In some cases the 25% rule will result in LTACHs voluntarily decertifying from the Medicare program, which will only further increase the impact of the 25% rule on LTACHs remaining in the same service area. The same reasons that lead CMS to initially establish a grandfathering provision at 43 C.F.R. 412.22(f) is relevant to the application of the proposed rule to freestanding and under-development LTACHs. As observed in the August 1, 2003 IPPS update final rule for FY 2003, "in establishing grandfathering provisions, [CMS's] general intent has been to protect existing hospitals from the potentially adverse impact of recent, more specific regulations that we now believe to be essential to the goals of the Medicare program." 68 Fed. Reg. at 45,463. If CMS insists on implementing the payment limitation threshold on all admissions from non-co-located hospitals, CMS should afford existing freestanding and under-development LTACHs with the same protection it granted to HIHs existing on or before September 30, 1995.

i. CMS Has Not Provided the Data to Support Its Estimate of a 2.2% Reduction in Aggregate LTACH Payments for RY 2008 Due to the Proposed Expansion of the 25% Rule

Without this data, ALTHA cannot provide meaningful comments on this aspect of the proposed rule. After the proposed rule was published, Reed Smith, LLP filed an expedited request under the Freedom of Information Act ("FOIA") for this data, but to date it has not been provided. We will need to review that data in order to verify the accuracy of this estimate.

j. It Is Unclear How CMS Will Apply the Proposed Rule

CMS has not clearly stated how the proposal to expand the 25% rule would be applied to LTACHs and STACHs, but to be consistent with current CMS policy it would need to be applied in a "site-specific" manner, rather than by Medicare provider number. In other words, the percentage of an LTACH's discharges admitted from a remote campus or satellite of a referring hospital that exceed 25% (or the applicable percentage) would be calculated separately from the percentage of the LTACH's discharges admitted from a referring hospital's main campus. To apply the proposed rule in any other fashion would have a disparate impact among LTACH providers based solely on the structure of general hospital services within a particular community. For example, an LTACH located in a community that experienced substantial market consolidation among STACHs would be severely disadvantaged as compared to an LTACH located in a community with a larger number of similarly sized STACHs. Furthermore, hospitals primarily arrange referral and discharge relationships by site, not according to Medicare provider number. The application of the 25% rule in any manner other than site-specific is entirely incompatible with the stated purpose of the proposed rule. If the proposed rule seeks to "expand" the 25% rule to freestanding LTACHs, then the rule should continue to be applied on a site-specific manner as it was to LTACH HIHs and satellites. To do otherwise, would result in a substantial change in CMS policy.

We understand from correspondence with CMS that the proposed rule would apply to each individual hospital referral source to the LTACH, regardless of whether the patient was admitted from a hospital located in the same building or on the same campus of the LTACH or satellite. From the same correspondence, it is our understanding that, if an LTACH has a remote campus or satellite operating under the same provider number, and more than one LTACH location admits patients from the same hospital referral source, the 25% threshold (or other applicable percentage) will be separately calculated by LTACH location. As a reading of the proposed rule and the accompanying preamble may lead to several interpretations of how the 25% rule would be applied in this scenario, we ask that CMS explicitly confirm that the proposed rule, if adopted, will be applied in a site-specific manner.

3. ALTHA Position and Alternatives

For the reasons discussed above, and based on the data presented, CMS should not finalize the proposed, or any similar, policy that extends the current 25% rule to freestanding LTACHs or grandfathered LTACHs. However, if CMS finalizes this policy, it should modify that policy in the following ways:

- Grandfather all existing and under-development freestanding LTACHs from the rule altogether.
- Not revoke grandfather status for HIHs currently afforded grandfather status.
- Set the applicable percentage for all freestanding LTACHs at least at 50% in light of the lesser policy concerns CMS has with these hospitals as compared to HIHs and satellites.
- Set the applicable percentage for all LTACHs in underserved areas (rural, MSA dominant, and urban single) at 75% in light of the disparate impact this policy will have on these hospitals.
- Provide for a longer phase-in period – at least as long as the phase-in period for HIHs and satellites (4 years).
- Under its own rationale CMS must limit the 25% rule extension to LTACH discharges that had the same DRG upon discharge from the STACH. In addition, the "IPPS equivalent" payment amount should be based on the DRG assigned to the patient in the STACH.

B. Short Stay Outlier ("SSO") Policy Proposal

1. Summary of Proposal

The proposed rule would revise the payment adjustment formula for short stay outlier ("SSO") patients. SSO cases are defined as LTACH 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) 100% of estimated patient costs; (2) 120% of the per diem of the LTC-DRG multiplied by the length of stay of that discharge; (3) the full LTC-DRG payment; or (4) a blend of 120% of the LTC-DRG specific per diem amount and an amount comparable to the IPPS per diem amount.

In the preamble to the proposed rule, CMS indicates that it is considering lowering LTACH payment to the IPPS rate for cases with a length of stay that is less than the average length of stay plus one standard deviation for the same DRG under IPPS (the so-called "IPPS comparable threshold"). Under the proposal, SSO cases with covered lengths of stay that exceed the IPPS comparable threshold would continue to be paid under the current SSO payment policy. Cases with a covered length of stay less than or equal to the IPPS comparable threshold will be paid at an amount comparable to the IPPS per diem. As justification for the change in policy, CMS cites DRG 475 (Respiratory system diagnosis with ventilator support) and DRG 483 (Trach with mechanical vent 96+ hours or PDX except face, mouth and neck diagnosis) as examples where the number of "recuperative" days are considerably shorter at the STACH if the discharge from the STACH was followed by an admission to an LTACH. CMS asserts that the discharge data for DRG 475 and DRG 483 support the belief that STACHs are discharging patients to LTACHs "early," before completing their episode of care and that LTACHs are admitting some SSO patients who should have remained at the STACH.

CMS advocates this change based on an assumption that the same DRG should not be paid more under LTACH-PPS if a covered length of stay in an LTACH is less than or equal to the IPPS average length of stay plus one standard deviation. CMS asserts that SSO cases with similar length of stays as the average length of stay for short-term STACH patients require similar resources and, as a result, should be paid at the IPPS rate. CMS believes that it is "overpaying" for SSO cases in LTACHs with covered lengths of stay that are equal to or less than the typical IPPS average length of stay.

In the preamble to the proposed rule, CMS repeatedly raises the concern that under the existing SSO policy "these cases most likely did not receive a full course of a LTCH-level treatment in such a short period of time and the full LTC-DRG payment would generally not be appropriate." 72 Fed. Reg. at 4,804. CMS remains convinced that "many SSO patients could otherwise have continued to receive appropriate care in the STACH from which they were admitted." 72 Fed. Reg. at 4,805. In other words, CMS offers the same rationale offered for proposing to extend the 25% rule to free-standing LTACHs, namely, that Medicare should not be paying twice for a single episode of care. For these reasons, CMS announced in the proposed rule that it is considering lowering LTACH payment to the IPPS rate for SSO cases with a length of stay of less than the IPPS comparable threshold.

CMS estimates the impact of this proposal as a 0.9% decrease in aggregate LTACH payments.

2. ALTHA Response

a. CMS Must Propose Regulatory Language Before It Can Finalize This Proposal

In the preamble to the proposed rule, CMS stated that it is considering a change to its SSO policy, and requested comments on the proposed policy. However, in violation of section 533(b) of the Administrative Procedure Act ("APA"), CMS provided no specific regulatory language to implement this proposed policy. See 5 U.S.C. § 533(b)(requiring a notice of proposed rulemaking to include "the

terms or substance of the proposed rule"). Without adequate notice of the regulatory language that CMS intends to use, interested parties are improperly limited in the degree to which they are able participate in the rulemaking process. See United Church Board for World Ministries v. SEC, 617 F. Supp. 837, 840 (D. D.C. 1985) ("A general request for comments is not adequate notice of a proposed rule change. Interested parties are unable to participate meaningfully in the rulemaking process without some notice of the direction in which the agency proposes to go.") Moreover, courts have consistently found that where notice is not "clear and to the point," it is inadequate and the agency's "consideration of the comments received in response thereto, no matter how careful, cannot cure the defect." McLouth Steel Products Corporation v. Thomas, 267 U.S. App. D.C. 367 (D.C. Cir. 1988) (citing cases) (citations omitted). Accordingly, regardless of whether it receives comments on its proposal, CMS may not implement this policy in a final rule until it publishes sufficient notice in the form of substantive regulatory language pursuant to section 533(b) of the APA and as required by interpretive case law.

b. Expanding the SSO Policy Is Premature When CMS Has Failed to Evaluate the Effect of Changes to the Policy Implemented Less Than One Year Ago

The existing SSO policy became effective as recently as October 1, 2006. Consequently, the most recent changes to the SSO policy will have been in effect for less than one year before the proposed change would take effect. In the preamble to the proposed rule, CMS states that "[s]ubsequent to the RY 2007 LTACH PPS final rule, we have performed additional analysis of more recent [sic] FY 2005 MedPAR data." 72 Fed. Reg. at 4,805. However, analysis of FY 2005 data does not take into account changes implemented to the SSO policy in the RY 2007 final rule. CMS is proposing a change to an existing policy whose current impact is undetermined. In justifying the most recent change to the SSO policy, CMS declared that it "formulated a payment adjustment under the LTACH PPS that [CMS] believed would result in an appropriate payment adjustment for those inpatient stays that [CMS believes] are not characteristic of LTACHs but could be more appropriately treated in another setting." Id. Before rushing to adopt another change to the SSO policy, CMS should determine if the change implemented in RY 2007 met the intended goal. There has been insufficient time to determine the impact of the last change to the SSO policy.

After the SSO policy changes of last year, LTACHs no longer have an incentive to knowingly admit these kinds of SSO cases. By reducing the option that SSO cases be paid 100% of the estimated cost of the case from 120% of costs, the RY 2007 final rule adequately discouraged the inappropriate admission of patients that do not typically belong in LTACHs, but who would be more appropriately treated in another setting. Reducing the SSO payment further will result in additional cuts in LTACH payment before LTACHs, or CMS, have assessed the impact of the prior year's reduction.

c. CMS Incorrectly Assumes that SSO Cases with a Similar Length of Stay as STACH Cases Are Continuing the Same Episode of Care

As described above and in the following subsections, there is no data to support the conclusion that patients within the IPPS comparable threshold are clinically similar to STACH patients or have continued the same episode of care that began in the STACH. Accordingly, these cases should not be subject to payment comparable to the IPPS per diem amount. As demonstrated on pages 10 through 19 above:

1. LTACH Patients Discharged from STACHs are assigned Different DRGs in the Two settings for two separate Episodes of Care (see pages 10 through 19 and Figure 1 through 9 and Table 2) and

2. The Most Common LTACH Patient – Those dependent on ventilators with tracheotomies – are assigned different DRGs in the STACH and LTACH reflecting a different episode of Care (see pages 19 through 20).

The flaw in CMS's premise is graphically illustrated with the most common discharge DRG for LTACHs, DRG 475 (Ventilator Dependent Patients). As discussed at length above, the vast majority of LTACH patients assigned an LTC-DRG of 475 were not assigned an acute hospital DRG of 475 upon discharge from the STACH. Instead, most of these patients were assigned a DRG of 561 or 562, reflecting the clinical fact that in addition to a ventilator these patients received surgical implantation of a tracheotomy. This clinical characteristic reflects a profound difference in patients. It also underscores the fallacy of CMS's proposed payment adjustment. STACH patients with a DRG of 475 are fundamentally different in terms of clinical characteristics, costs, severity of illness and length of stay from the LTACH DRG 475 patient. Evidence of these differences appears in the basic fact that the majority of patients discharged from STACHs with a DRG of 475 **are discharged without even being on a ventilator.** These patients were assigned a discharge DRG of 475 because at some point during their acute hospital stay they were placed on a ventilator and the DRG coding software requires that DRG 475 be assigned under these circumstances. To use the acute DRG 475 payment level to pay for LTC-DRG 475 patients ignores fundamental differences in the patient populations.

To examine this issue the University of Louisville School of Public Health analyzed 285 patient discharges from a large, urban acute care hospital in Louisville, Kentucky. All 285 patients were assigned a DRG code related to ventilators, either DRG 475 (ventilator dependent) or DRGs 541/542 (ventilator dependent with a tracheotomy). Key findings were as follows:

- 81% of live patients discharged with a DRG of 475 were discharged without being on a ventilator. In other words, the vast majority was placed on a ventilator for some period of time in the STACH, but had been taken off the ventilator prior to discharge. Only a small fraction of these patients (8%) were admitted to LTACHs and instead went to other post-acute settings such as SNFs, IRFs or home health. A majority of the DRG 475 patients discharged still on a ventilator were admitted to LTACHs (68%).

- In contrast, 59% of live patients discharged with a DRG of 541/542 (ventilator with tracheotomy) were discharged while still on a ventilator. The overwhelming majority of these patients (97%) were admitted to LTACHs. These patients are assigned LTC-DRG 475 upon discharge from the LTACH. A majority of the DRG 541/542 patients discharged off of ventilators (67%) went to post-acute settings other than LTACHs.

The implication of this data on CMS's SSO policy discussion is profound. CMS proposes to pay LTACHs the IPPS rate for DRG 475 patients when the patients are fundamentally different. A large majority of STACH DRG 475 patients leave the STACH without even being on a ventilator, which reflects a fundamentally different clinical profile and cost than the LTACH DRG 475 patient. The LTACH DRG 475 patient typically is not only dependent on a ventilator but also received surgical implantation of a tracheotomy during their previous acute care hospital stay. These patients have a higher severity of illness, consume many more resources and, consequently, Medicare payments are higher to account for these clinical characteristics. The proposed change in the SSO policy ignores this fact.

CMS should not make changes to the SSO policy. If CMS does so, in order to be logically consistent, it must be assumed that LTACH cases within the IPPS comparable threshold are comparable to IPPS cases and the LTACH should be paid the IPPS rate based on the DRG that was assigned to the patient upon discharge from the STACH. In the case of the LTACH DRG 475 patient, the LTACH should be paid at a rate comparable to IPPS DRGs 541/542, reflecting the fact that the acute "episode of care" was for a patient on a ventilator as well as receiving a tracheotomy.

d. The Proposed Policy Incorrectly Concludes that LTACH SSO Cases are Clinically Similar to STACH Patients With Similar Lengths of Stay

In the discussion of SSO cases, CMS repeats its conviction that many SSO patients could have continued their treatment in the STACH, but were instead prematurely transferred. CMS identifies certain SSO cases as having an episode of care in the LTACH that closely resemble the episode of care in the STACH. This premise, on which the proposed change in policy is based, is flawed because CMS is comparing LTACH SSO cases to STACH cases based solely on their length of stay. This rudimentary comparison does not take into consideration patient severity of illness, which clearly shows that LTACH and STACH patients with the same DRG are not the same kinds of patients. An analysis of these "IPPS comparable cases" using MedPAR 2005 data and the APR-DRG Grouper shows that very short-stay outliers ("VSSOs")[7] are more clinically similar to other LATCH cases than STACH cases in terms of their acuity. As Table 3 below indicates, for 5 of the most common LTACH cases, the SSO cases have a similar percentage of cases in severity of illness ("SOI") categories 3 and 4 as all LTACH cases, and a much higher percentage of cases in SOI categories 3 and 4 than STACH patients.

Table 3

DRG	STACH CASES: GMLOS	% in SOI 3,4	% in ROM 3, 4	LTACH SSO CASES: ALOS	% in SOI 3, 4	% in ROM 3, 4	All LTACH CASES: GMLOS	% in SOI 3, 4	% in ROM 3,4
475	8.0	96%	89%	14.7	94%	83%	34.2	94%	82%
87	4.9	72%	57%	13.4	88%	67%	24.8	91%	71%
88	4.0	26%	14%	9.8	53%	32%	19.3	60%	38%
271	4.6	43%	20%	13.2	73%	47%	26.9	74%	45%
89	4.6	44%	19%	10.0	69%	37%	20.6	75%	37%
All DRGs	4.3	25%	14%	12.8	66%	47%	26.6	69%	48%

Table 4 below excludes SSO data and replaces it with VSSO data. As you can see, the SOI scores for the VSSOs are on par with, and actually slightly higher than, the SOI scores for all LTACH cases.

Table 4

DRG	STACH CASES: GMLOS	% in SOI 3,4	% in ROM 3, 4	LTACH VSSO CASES: ALOS	% in SOI 3, 4	% in ROM 3, 4	All LTACH CASES: GMLOS	% in SOI 3, 4	% in ROM 3,4
475	8.0	96%	89%	10.1	94%	85%	34.2	94%	82%
87	4.9	72%	57%	5.7	87%	71%	24.8	91%	71%
88	4.0	26%	14%	4.7	52%	34%	19.3	60%	38%
271	4.6	43%	20%	6.1	74%	49%	26.9	74%	45%
89	4.6	44%	19%	5.1	70%	43%	20.6	75%	37%
All DRGs	4.3	25%	14%	7.5	71%	55%	26.6	69%	48%

[7] For purposes of this letter, ALTHA has adopted CMS's definition of very short-stay outliers as those cases where a LTACH patient's covered LOS at the LTACH is less than or equal to the ALOS plus one standard deviation for the same DRG at a STACH or the "IPPS comparable threshold." Despite ALTHA's use of this terminology, we do not agree that these cases actually have short stays. For example, DRG 565 patients with a LOS of 23 days are just below the IPPS comparable threshold, but can not be considered short stay patients as their LOS is so close to the 25-day LTACH threshold.

Table 4 illustrates the significant difference in SOI in VSSO cases compared to STACHs. As ALTHA has noted in previous comment letters, it is not possible for an LTACH to determine upon admission the patient's length of stay and DRG classification when these patients appear clinically similar to other patients admitted to an LTACH, as Table 4 indicates. Because these cases are clinically similar to other LTACH cases, ALTHA believes it is appropriate for CMS to pay for them under the LTACH PPS. The average medical complexity (as measured by SOI and ROM) and length of stay of VSSO cases are far higher than for STACH patients, and thus it is not surprising that the average costs for VSSO patients are above the IPPS DRG payment amounts. Since there is no evidence that VSSOs are in any way similar to STACH patients, there is no basis for paying for such cases using IPPS methodology.

e. It Is Inappropriate to Base LTACH Reimbursement Policy on the Length of Stay Distribution of Short Term Acute Care Hospitals

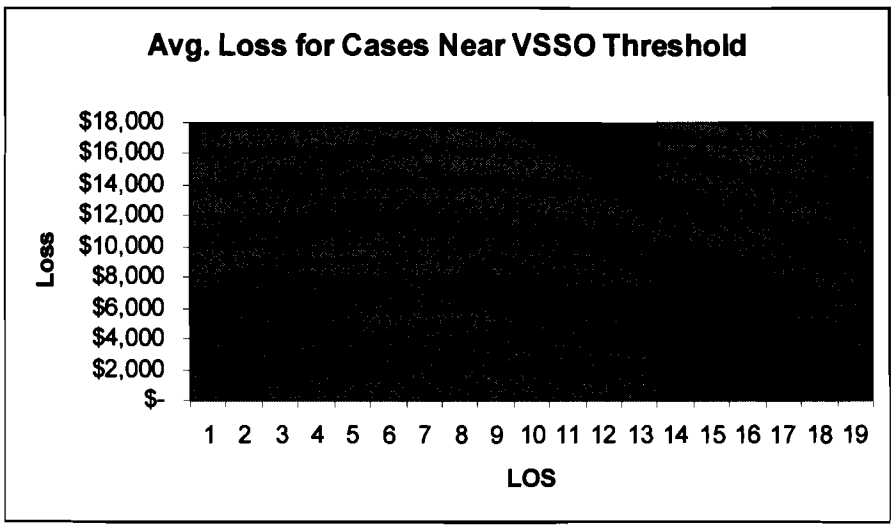
Superimposing STACH LOS distribution patterns, especially in instances where there are large standard deviations, on LTACH patients as a way of defining LTACH patients is not supported by data or common sense. Using the IPPS ALOS plus one standard deviation methodology to describe very-short-stay LTACH cases results in 8 DRGs in which the IPPS comparable threshold exceeds 25 days, the statutorily-defined ALOS for LTACH patients. For example DRG 504 (Extensive Burns or Full Thickness Burns) has a GMLOS of 37.1 days and the SSO threshold is 30.9 days. According to CMS's methodology for determining LTACH patients that are VSSOs, DRG 504 burn cases staying less than 48.4 days in the LTACH would fall into this category. There are 13 DRGs according to CMS's table in the proposed regulation in which the IPPS comparable threshold is longer than the short-stay outlier threshold (5/6th the GMLOS), meaning that patients with LOS longer than the short-stay outlier threshold would fall into this new category of patient. The CMS methodology is inherently flawed in defining VSSO LTACH cases.

Using LOS as the sole means of describing patients has its limitations. As discussed in this section, LTACH patients with relatively short stays are clinically similar to other LTACH patients, using severity of illness and risk of mortality scores from the APR-DRG Grouper. It is an arbitrary distinction to label clinically similar patients with LOS within a few days of each other as either "IPPS comparable" patients or LTACH patients. An example of this is DRG 565 (former DRG 475), patients on a ventilator more than 96 hours. DRG 565 patients staying 23 days are just below the IPPS comparable threshold but can not be described as short stay patients with a stay so close to the 25 day LTACH threshold. DRG 565 patients with stays less than the IPPS threshold have similar SOI and ROM scores as all other LTACH patients.

f. The Proposed Change Would Create a Significant Payment Cliff and Have a Disproportionate Impact on Longer Stay, Medically Complex Patients

Analysis of the proposed SSO payment methodology using MedPAR 2005 data indicates that 7,425 cases would have reduced payments under this policy change, and for all of these cases the methodology CMS discusses would pay LTACHs at rates below their costs. According to our analysis, approximately 55% of the cases that would receive a reduced payment are within 2 days of exceeding the IPPS comparable LOS for the DRG. Implementing this policy would create a payment cliff by paying dramatically different amounts for cases with similar lengths of stay on either side of the IPPS threshold. As Figure 10 illustrates, the size of the average payment cut increases as the length of stay increases for cases that would be subject to the VSSO policy and which are within 2 days of the SSO threshold.

Figure 10



Analysis of payment data in MedPAR suggest the average payment reduction under this policy for cases within two days of meeting the IPPS comparable threshold would be over $3,000. This difference is dramatic when considering that a majority of SSO cases are paid for at 100% of cost. In fact, almost half (46%) of the savings from this policy change would come from cases with a LOS within two days of the IPPS comparable threshold.

The policy would create an even larger payment cliff for patients with a LOS longer than 20 days (but below the IPPS threshold). MedPAR data indicate that the average payment reduction for the 350 VSSO cases with a LOS over 20 days would be over $5,000. For longer stay cases to face higher reductions in payments than short stay cases goes against CMS's goal for implementing this policy, which is to decrease incentives for LTACHs to admit very-short-stay patients. The policy would institute a larger payment penalty for stays over 20 days, which contradicts CMS's stated goal for discussing this payment option. Implementing this policy creates strange incentives for LTACHs because it would put them at greater financial risk when taking patients with relatively long stays. If CMS intends to create incentives for LTACHs to admit only patients with long stays, this policy would go against that incentive.

CMS's SSO policy has another perverse effect as it results in additional payment cuts for the most medically complex LTACH patients that reach high cost outlier status. This is because overall LTACH payment reductions such as the SSO provision raises the financial stop loss threshold that LTACHs must incur before receiving high cost outlier payments since the LTACH payment methodology limits high cost outlier payments to 8% of total LTACH payments. Consequently, in an unsuccessful effort to target payments cuts at "very short stay" patients, CMS not only fails to achieve this goal but also penalizes LTACHs who treat the longest stay, most medically complex and expensive to treat patients.

g. The Proposed Policy Does Not Account for the Portion of SSO Cases that Expire at the LTACH

In developing the proposed changes to LTACH payments for SSO cases, CMS makes the false assumption that LTACHs can predict in advance the expected length of stay for medically complex LTACH patients. From a clinical perspective, there are no discernable differences between "short-stay" LTACH patients and longer stay ("inlier") LTACH patients. Physicians who make admission decisions

after applying objective and rigorous clinical screening criteria cannot, indeed *should* not, predict in advance the length of stay for this small subset of medically complex, severely ill patients.

Consistent with the fact that SSO patients require the same level of care as inlier patients, LTACHs are unable to distinguish between these two patient populations at the time of admission. (For the same reason, LTACHs 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.) 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 $5/6^{th}$ geometric stay thresholds are different for each LTC-DRG, it is impossible to predict whether a patient will be a SSO upon admission.

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 LTACHs 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 LTACHs already have had extended stays at acute care hospitals, making it even more difficult to predict how long they will stay.

The SSO policy would penalize LTACHs for admitting LTACH-appropriate patients by paying providers below cost most of the time. Currently, most LTACHs 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 LTACHs ("Report to the Congress: New Approaches in Medicare," June 2004) and are used by many of Medicare's QIOs to evaluate the appropriateness of LTACH admissions. LTACH 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 LTACH stay are admitted.

In last year's proposed rule, CMS hypothesized that LTACHs seek to admit patients who are likely to be SSO cases because LTACHs financially benefit from treating SSO patients. In reality, however, LTACH 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 LTACH 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 LTACH 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. LTACHs should not be penalized for achieving clinical outcomes in shorter periods of time – the successful outcome everyone wants.

In addition, CMS's premise that LTACHs have an incentive to target SSO cases for admission is flawed. Even if LTACHs 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, LTACHs have a *disincentive*, not an incentive, to admit short-stay cases. This is because the admission of short-stay cases lowers an LTACH's average length of stay and puts the LTACH at risk losing its certification status due to a failure maintain the required average length of stay of greater than 25 days.

h. The Proposed Rule Defies the Basic Premise of LTACH PPS

Basing LTACH payment on IPPS per diem rates violates the statutory requirement that CMS reimburse LTACHs on a per discharge basis that reflects the differences in patient resources and costs for hospitals having an average length of stay of greater than 25 days. The statutory definition of an LTACH, the statutory directive for an LTACH PPS, and the entire framework of the LTACH PPS are based upon reimbursing LTACHs for Medicare inpatients who ***on average and in the aggregate*** have a length of stay of greater than 25 days. The policy CMS is proposing, as with prior SSO policies, violates this cornerstone of LTACH reimbursement law and erodes the PPS.

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 LTACH 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). By paying LTACH SSO cases at IPPS rates, CMS violates the will of Congress and CMS's own understanding of the legislative intent behind the IPPS and LTACH PPS. In the August 2002 final rulemaking that established the LTACH 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, LTACHs, 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 LTACHs at rates comparable to the IPPS rates for SSO patients. To do so would violate the law of averages upon which the LTACH PPS is based, and the clear will of Congress and previous statements by HHS and CMS that STACH reimbursement does not adequately compensate LTACHs.

CMS's proposed policy violates the structure of LTACH PPS. LTACH 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, LTACH PPS is designed to create an incentive for LTACHs to furnish the most efficient care possible to each patient, and imposes on LTACHs 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 LTACH patients will be below the average. Payment for these cases based on LTC-DRG rates is fully consistent with the underpinnings of LTACH PPS, since LTACHs 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 LTACH PPS.

In fact, the percentage of LTACH 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% of the average LTC-DRG specific per diem amount, as was discussed in the March 2002 Proposed Rule, about half of the LTACH cases would have been treated as SSO cases.) In addition, in an LTACH, 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 LTACH patients fall below 5/6 of the average length of stay for each LTC-DRG is entirely expected as a fundamental feature of LTACH PPS and provides no information whatsoever about the appropriateness of a given patient's admission to the LTACH in the first instance.

CMS states "[w]e believe that the 37% of LTACH discharges (that is, more than one-third of all LTACH 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% total. Assuming that the GMLOS is defined as the point at which the lengths of stay of 50% of patients are above and 50% are below, then taking $5/6^{th}$ of the GMLOS will consistently produce a percent of patients that is around 42%. That is, $5/6^{th}$ of 50% is always 42 percent. As the LOS change each year and the GMLOS is recalibrated annually, the $5/6^{th}$ 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% 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 that 41.7% of these cases fell below $5/6^{th}$ of the short-term hospital GMLOS.

3. ALTHA Position and Alternatives

CMS should wait until data is available to evaluate the effectiveness of its SSO policy changes from last year before making this or any further changes. ALTHA strongly encourages CMS to delay further changes in the SSO policy until after reviewing relevant data and proposing specific regulatory language. To date, CMS has produced no study or analysis showing that inappropriate admissions constitute a material portion of SSO cases and, to the contrary, the data presented above demonstrates that SSO cases are, in fact, appropriate for admission to LTACHs.

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. CMS should be well aware that the rate of payment for these cases will be insufficient to cover LTACHs' reasonable and necessary costs in providing care to SSO patients. Furthermore, the proposed policy violates the statutory requirement that CMS reimburse LTACHs on a per discharge basis that reflects the reasonable and necessary cost of providing services in a hospital having an average length of stay of greater than 25 days.

C. Market Basket Increase and Overall Payment Adequacy

1. Summary of Proposal

For FY 2008, CMS estimates that the market basket increase from July 1, 2007 to June 30, 2008 will be 3.2%. After an adjustment to account for the increase in case-mix in FY 2005 of 2.49%, CMS proposes to update the standard Federal rate by 0.71% for FY 2008. As a result, the Federal rate for FY 2008 will equal $38,356.45, unless the final Federal rate for FY 2008 is updated in the final rule based on more recent data. CMS explicitly retained the ability to update to the standard Federal rate in the final rule. Furthermore, CMS offers to consider other data sources that could be used to determine a proxy for "real" LTACH PPS case-mix change, other than the 1.0 to 1.4% per year case-mix parameters based on a study by RAND. The "real" case-mix index increase is defined as the increase in the average LTC-DRG relative weights resulting from the hospital's treatment of more resource intensive patients. CMS contends that changes in the case-mix index result from a combination of "real" changes and "apparent" changes. Apparent changes are defined as increases in the cost-mix index due entirely to changes in coding practices. In order to limit what CMS considers are apparent changes to the case-mix index, CMS is soliciting comments on other date sources for determining the change in the real case mix.

2. ALTHA Response

a. LTACH Margins Demonstrate that a 0.7% Increase in the Standard Federal Rate Is Inadequate

In recent years, CMS has made numerous changes to LTACH PPS that have slowed growth in new LTACHs and controlled margins. In addition to the existing 25% rule, CMS reweighted the DRGs in October of 2005 and again in October of 2006, the former causing a 4.2% reduction in rates and the latter causing a 1.4% reduction in rates. Effective July of 2006, CMS reduced payment to short stay outliers by 3.7% and made no increase in the market basket update. The proposed rule is estimated to further decrease SSO payments another 0.9%. The cumulative effect of these payment changes has been to bring LTACH margins close to zero. Based upon MedPAC's margin analysis, CMS is proposing rates below LTACH providers' cost of care. Without even considering the cumulative effect of the proposed changes, MedPAC estimates margins of 0.1% to 1.9% for LTACHs.

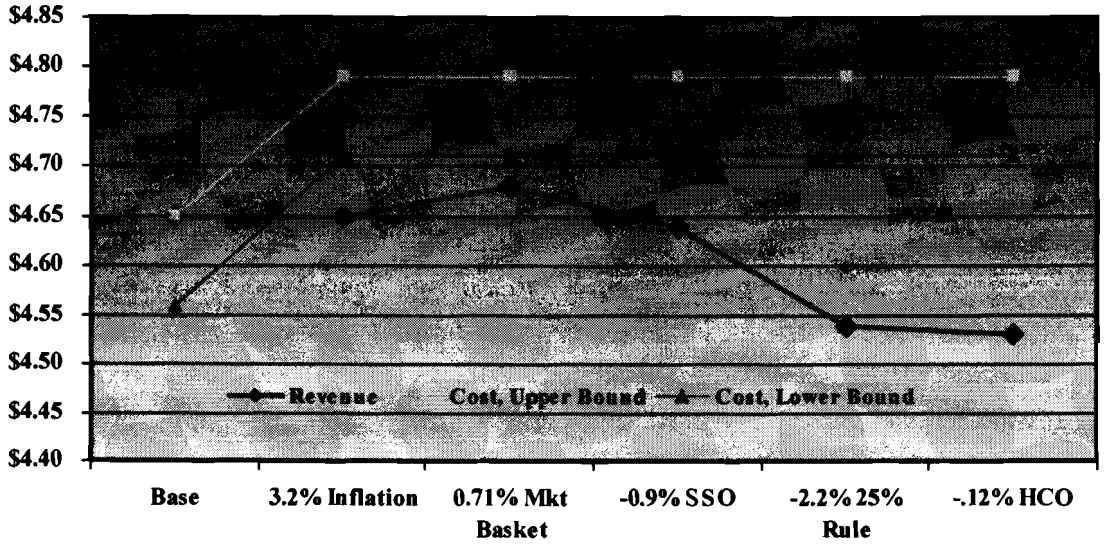
In the proposed rule, CMS states that under the proposed changes (*i.e.* VSSO payment reduction, reduced market basket update of 0.71%, and payments based on the inpatient PPS for admissions exceeding 25% from a single referral source) that payments will be adequate. However, detailed analysis of expected LTACH margins under these proposed payment rules indicates that CMS is proposing inadequate payment rates to LTACHs. In order to determine the impact of the proposed changes, ALTHA evaluated the proposed policy changes using the CMS impact analysis table to calculate margins for RY 2008. In addition to the policies for which CMS published an estimated impact, ALTHA also calculated an estimated impact for the change in the high cost outlier ("HCO") fixed-loss threshold. Using MedPAC estimated margins for FY 2007 as a base for comparison, ALTHA estimates that margins for RY 2008 would be negative 3.7% to negative 5.7%. See Table 5 below. ALTHA strongly disagrees that payments to LTACHs under the rates proposed by CMS will be adequate. Our analysis shows that the cumulative impact of changes to LTACH PPS is so dramatic as to make the payment levels unsustainable.

Table 5

[illegible]	Revenue Change	Cost Change	Estimated Revenue	Estimated Costs, Lower Bounds	Estimated Costs, Upper Bounds
Base Estimate			$4.65	$4.65	$4.56
Proposed Policies					
Market Basket	0.71%		$4.68	$4.65	$4.56
Short-Stay Outlier	-0.9%		$4.64	$4.65	$4.56
Expansion of 25% Rule	-2.2%		$4.54	$4.65	$4.56
HCO Fixed-Loss Threshold	-0.12%		$4.53	$4.65	$4.56
Price Inflation		3.2%	$4.53	$4.79	$4.71
Margin				**-5.7%**	**-3.7%**

Using the CMS base revenue estimate of $4.65 billion for RY 2008, we estimate two cost levels (upper bounds and lower bounds) to account for both margin scenarios. Table 6 shows that the cumulative effect of changes in LTACH PPS is to reduce reimbursement below even the lowest estimate of costs.

Table 6



A fundamental premise of the Medicare program and its payment systems is that Medicare should not knowingly reimburse providers and suppliers below the cost of care. This premise is reflected in the budget neutrality requirement that Congress established for the LTACH PPS. As CMS repeatedly acknowledged in the preamble to the final rule implementing the LTACH PPS, Section 1886(e)(1)(B) of the SSA [42 U.S.C. 1395ww(e)(1)(B)] requires the Secretary to maintain budget neutrality by ensuring that "aggregate payment amounts [under the PSS] are not greater or less than "the payment amounts which would have been payable for such services for those same hospitals for that fiscal year under this section under the law as in effect before the date of enactment of the Social Security Amendments of 1983." See 67 Fed. Reg. 56027 ("Section 123(a)(1) of Public Law 106–113 [Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA)] requires that the

prospective payment system for LTACHs maintain budget neutrality."); 67 Fed. Reg. at 56036 ("As we discussed in the proposed rule, consistent with the statutory requirement for budget neutrality, we intend for estimated aggregate payments under the LTACH prospective payment system to equal the estimated aggregate payments that would be made if the LTACH prospective payment system would not be implemented."); 67 Fed. Reg. at 56046 ("Consistent with the statutory requirement for budget neutrality, we intend for estimated aggregate payments under the LTACH prospective payment system to equal the estimated aggregate payments that would be made if the LTACH prospective payment system were not implemented.") Contrary to this premise, CMS now proposes a set of policies that would reduce LTACH margins for RY 2008 from a negative 3.7% to negative 5.7%. ALTHA is greatly concerned that the proposed rule violates this premise, and perhaps the underpinnings of Medicare provider agreements with LTACHs, to knowingly reimburse LTACHs below cost. Further, as CMS acknowledges, the goal of prospective payment per discharge reimbursement is to encourage providers to treat patients efficiently, see 67 Fed. Reg. at 55999, not force them to provide substandard quality care or drive them out of business.

b. The Purpose of the Market Basket Increase Is to Account for the Expected Increases in Price Inputs for the Upcoming Year

The market basket increase is designed to address increases in the cost of goods and services required to deliver LTACH services. Case-mix is only one element that might influence the price of inputs; other elements include increases in wages, drugs, products, supplies, etc. In proposing a 0.71% increase, CMS has not considered these other elements of the market basket. Changes in case-mix dominate the method used by CMS to propose an update to the market basket, even though case-mix has little to do with price inputs that comprise the market basket. This position conflicts with CMS's statements in connection with its proposal to annually reweight the LTC-DRGs in a budget neutral manner, where CMS makes clear that so-called apparent case-mix is no longer a concern.

For RY 2008, CMS calculates that price inflation will be 3.2% using the Rehabilitation, Psychiatric, Long Term Care ("RPL") market basket. The market basket captures the change in the price of items and services Medicare providers purchase to treat Medicare beneficiaries. The market basket update is applied to the standard Federal rate so that it reflects the cost of providing care to Medicare beneficiaries over the coming rate year. Even though CMS estimates that input prices will increase by 3.2% over RY 2008, the agency is proposing to not update the LTACH standard Federal rate by an equivalent percentage. Instead, CMS is proposing to pay LTACHs at a level that does not reflect current costs of treating Medicare patients. The proposal to pay LTACHs for treating Medicare beneficiaries at a rate that does not reflect an increase in input prices is particularly troubling because LTACH Medicare margins were estimated to be between 0.1% and 1.9% by MedPAC *prior to* this CMS proposal.[8]

CMS designed the RPL market basket to reflect the specific input cost structures of rehabilitation, psychiatric and long-term care hospitals. The cost inputs in the RPL market basket include: employee compensation, professional fees, utilities, professional liability insurance, capital-related costs, and other products and services such as pharmaceuticals and medical instruments. The cost component categories are derived from the cost reports that were filed by these three provider types in 2002. CMS uses price indexes such as the employment cost index for wages and salaries and the producer price index for pharmaceuticals to measure how the price of each of the cost components changes from one year to the next. On an annual basis, CMS updates the market basket index by multiplying the most recent price index level change times the weight of the relevant cost component. The sum of all of the multiplications is the market basket update.

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8 See MedPAC March 2007 Report to Congress: Medicare Payment Policy, pg. 220, available at: http://www.medpac.gov/publications/congressional_reports/ Mar07_Ch03d.pdf.

Because the purpose of the market basket is to prospectively adjust the standard Federal rate to account for changes in price, there is no component of the market basket related to historical changes in case-mix. Case-mix change is measured by comparing the case weights for LTACH patients from one year to the next. Changes in case-mix may indirectly be reflected in the market basket if those changes affect the kinds of items and services these providers purchase; however, these changes would only be reflected in the market basket when CMS revises and rebases the market basket. For the most part, changes in case-mix would never be reflected in the market basket.

Within the LTACH PPS each component of the system has a function that is designed to calculate an accurate payment to providers (*e.g.* the LTC-DRG weights adjust the standard Federal rate to reflect the resource intensity related to the patient's diagnosis and the wage index adjusts for local variation in wage levels). In this system the function of the market basket is to account for the increase in prices of the items and services that LTACHs purchase in order to treat Medicare beneficiaries. There is no component of the PPS other than the market basket update that accounts for changes in the price of the items and services LTACHs purchase. CMS describes the role of the market basket in calculating the prospective payment rate at sections 412.523(a)(2) and 412.523(c)(2), which state that payment is calculated at:

> (a)(2) A rate of increase factor to adjust for the most recent estimate of increases in the prices of an appropriate market basket of goods and services included in covered inpatient long-term care hospital services.
>
> (c) (2) CMS applies the increase factor described [immediately above] to each hospital's cost per discharge determined [by averaging inpatient operating and capital-related costs per discharge using the best Medicare data available] to compute the cost per discharge.

The regulations do not contemplate changes in the case-mix as determinative of an appropriate market basket increase. CMS' reason for reducing the market basket update to account for "apparent" case mix increases in previous years is not a factor that has anything to do with the function of the market basket as applied in regulations to LTACH providers in current years. There is no basis in this regulation for adjusting the market basket update based on "apparent" case mix or any other case mix factors. CMS has not explained in any understandable fashion how case mix changes relate to changes in the price of inputs measured by the market basket update. Basing the market basket almost entirely on changes to the case-mix in prior years is an improper method of updating the standard Federal rate.

c. There Is No Basis for Offsetting Market Basket Increase with Case-Mix Increase of Prior Years

In the proposed rule, CMS states that the reason for proposing a reduction in the market basket update is to account for "apparent" case-mix increases in previous years. CMS defines "apparent" case-mix increases as that portion of the total increase in the case-mix index due to changes in coding practices. No where in the code of Federal regulation does CMS state that a function of the market basket is to account for changes in case-mix attributable to "apparent" case-mix or state that the standard Federal rate may be adjusted for "apparent" case-mix. At § 412.523 CMS lists adjustments it may make to the standard Federal rate, including adjustments for outlier payments, budget neutrality during the transition, and a one-time budget neutrality adjustment. Case-mix changes are not included. Furthermore, there is no basis for reducing the case-mix increase based on claims data of FY 2004 and FY 2005. Other than the availability of data, CMS provides no logical explanation as to why an estimation of the "apparent" increase in case-mix derived from FY 2004 and FY 2005 claims should be applied to the market basket increase for RY 2008. This data has no relevance to changes in the price of LTACH services.

CMS provides no data suggesting that prices will do anything other than increase by 3.2% over RY 2008. CMS further presents no data indicating that market basket updates in prior years did not in fact reflect roughly the price increases in those earlier years. Based on CMS' own definition of how the market basket update is to be calculated and applied to LTACH providers, there is no basis to reduce the market basket update to account for changes in case mix. ALTHA believes that a full market basket update of 3.2% is warranted, and required under CMS' own regulatory language. Unfortunately, CMS may have lost sight of the purpose of the RPL market basket update and is thus failing to follow its own regulatory requirements for applying it. ALTHA requests, therefore, that CMS provide the full market basket update in the final rule.

d. CMS Has Not Provided Verifiable Data to Support the Assumption of "Apparent" Case-Mix

ALTHA believes that CMS has not explained adequately how case-mix changes are related to changes in the price of inputs measured by the market basket update and, therefore, ALTHA believes this proposal is not justified. The market basket update is a prospective measure of price inflation, and CMS provides no data suggesting that prices will not increase by 3.2% over RY 2008. CMS also does not provide any data showing that prices from 2004 to 2005 and from 2005 to 2006 (years included in the agency's case-mix analysis) increased less than the market basket update amount for those years. Considering CMS's definition of how the market basket update is calculated and applied to adjust the standard Federal rate, it is not appropriate to reduce the market basket update to account for changes in case-mix. ALTHA supports a full market basket update for RY 2008.

In its March 2007 "Report to the Congress: Medicare Payment Policy," MedPAC states that the LTACH Medicare margin range for FY 2007 is expected to be between 0.1% and 1.9%. MedPAC calculates the Medicare margin by subtracting Medicare costs from Medicare revenues and dividing by Medicare revenues. Holding volume of services constant, if Medicare costs (price) increase by 3.2% as CMS estimates, and revenues do not increase similarly because of the reduced market basket update CMS proposes, then Medicare margins would become negative through this proposal alone. Other CMS proposals included in this regulation would lower Medicare margins further. ALTHA estimates that the LTACH industry Medicare margin would be negative 3.7% and negative 5.7% for RY 2008.

e. Without Verifiable Data to Support Its Assumption of "Apparent" Case-Mix, CMS Is Applying an Unpredictable Method for Calculating the LTACH Market Basket Increase

CMS does not base the proposed update to the standard Federal rate on verifiable or relevant data. The update factor of 0.7 is calculated by subtracting the "observed" increase in the case-mix (3.49%) from the estimated increase in the market basket (3.2%) and then adding back what CMS deems the "real" case-mix increase (1.0%). To find the "real" case-mix increase, or the portion of the case-mix increase CMS attributes to an increase in treatment of resource intensive cases, CMS relies on the estimate of real case-mix increase based on a study of acute care hospitals published in 1991 and conducted on claim data from 1987 to 1988. CMS fails to explain how this old data is relevant to a different provider-type, especially a provider with a smaller subset of frequently used DRGs. Furthermore, CMS opted to accept the more conservative increase in case-mix (1.0%), rather than the upper bound of the RAND study (1.4%). CMS provides no justification for this choice.

While updating the market basket increase to account for unmeasured changes in coding practices, CMS simultaneously requests "comments on other data sources that could be used to determine a proxy for real LTCH PPS case-mix changes other than the 1.0 to 1.4 percent per year case-mix parameters based on the RAND study." 72 Fed. Reg. 4,792. "We believe that there is still ***some*** component of apparent CMI increase within the observed CMI increase of 3.49 percent that is due to coding practices rather than the treatment of more resource intensive patients." 72 Fed. Reg. 4,791. From CMS's own comments, it is clear that CMS has no confidence in the accuracy or relevance of the

estimated case-mix, yet this estimate has a substantial impact on the proposed market basket increase. ALTHA believes it is inappropriate to offset the increase in the market basket based on an unpredictable method of calculating the case-mix.

f. An Adjustment in the Market Basket Due to an "Apparent" Case-Mix Increase Is Inconsistent with CMS's Proposal to Implement Budget Neutral Reweighting of LTC-DRG

In determining the proposed update to the standard Federal rate for RY 2008, CMS adjusted the market basket update to reflect a belief that "some" component of the case mix increase is due to coding practices, rather than the treatment of more resource intensive patients. In the discussion of the market basket increase, CMS claims that the "apparent" case mix adjustment is necessary to protect "the integrity of the Medicare Trust Funds by ensuring that the LTCH PPS payment rates better reflect the true costs of treating LTCH patients." 72 Fed. Reg. 4,792.

Incompatible with this approach, CMS acknowledges in its discussion of the proposed budget neutrality requirement for the annual LTC-DRG update that changes to the case mix index are due to increased patient severity, rather than coding practices. "LTCH coding practice have stabilized such that the most recent available LTCH claims data now primarily reflect changes in the resources used by the average LTCH patient in a particular LTC-DRG (and not changes in coding practices)." 72 Fed. Reg. at 4,785. Despite its finding, CMS proposes to continue adjusting the case mix index based on a belief that increases in the case mix index in prior years (i.e. FY 2004 and FY 2005) is due in part to an unquantifiable change in coding practices. These inconsistent statements on the existence and impact of changes in coding practices underscores the need for CMS to reexamine its proposal to offset the market basket increase based solely on "apparent" increases in the case-mix.

It is inconsistent and punitive to offset the market basket increase based on case-mix increases in prior years. CMS must account for the increase in price inputs that raise the cost of resources LTACHs use in providing care to Medicare patients. If CMS is concerned with improper coding of services, the proper course of action is for QIOs to review claims data and address specific instances of abuse. Instead, CMS is assuming that the entire LTACH provider community has abused the payment system and, therefore, should receive a reduction in payment based on past coding practices.

g. The Proposed Market Basket Update Does Not Consider the Impact of the Increase in the High Cost Outlier Threshold

CMS has failed to consider the cumulative impact of all of its payment adjustments in proposing new policy changes, including the market basket adjustment. For example, CMS has not taken into consideration the impact of the increase in the high cost outlier threshold. CMS proposes to increase the HCO fixed loss threshold from $14,887 to $18,774 for RY 2008. This proposal increases the amount of costs for which the LTACH provider is not reimbursed by $3,887 before the case qualifies as a HCO case. The LTACH provider is reimbursed for 80% of the costs that exceed the $18,774 threshold. Analysis of the distribution of Medicare payments for HCOs using 2005 MedPAR data, adjusted to reflect the RY 2008 proposed fixed-loss amount, indicate that if the fixed loss threshold is increased by $3,887, 26% of cases would no longer meet the HCO threshold. ALTHA believes that reducing access to HCO payments for this many cases is not warranted, especially in an environment where CMS proposes to pay for so many cases below cost.

We calculated the effect of increasing the fixed-loss threshold amount from $14,887 to $18,774 using MedPAR 2005 cases for which there was an outlier payment. An analysis of the 2005 and proposed 2008 Federal base payment rates and fixed-loss thresholds indicates that they are roughly comparable and thus using 2005 MedPAR data are a good proxy (i.e. roughly equivalent number of cases would qualify for HCO payments) for estimating the impact of the increase in the fixed-loss amount for rate year 2008.

Table 7

RY 2005	$ 17,864	$ 36,833.69
RY 2007	$ 14,887	$ 38,086.04
RY 2008 proposed	$ 18,774	$ 38,356.45
Increase	$ 3,887	

For each case in the 2005 file with a high cost outlier payment, we calculated the amount of costs that exceeded the fixed-loss threshold for that case (costs = high cost outlier amount divided by 80% -- CMS reimburses 80% of costs above the threshold). We then counted the number of cases and reimbursement amounts that would not be made with an increase of $3,887 in the fixed-loss amount. As evident in Table 8 below, the effect on the number of cases was more striking than the reimbursement effect.

Table 8

LTACH Cases	136,289
HCO Cases	12,883
Mean HCO Payment	$21,752
HCO Cases Not Meeting Higher Fixed-Loss Threshold	3,376
Lost Cases, Share of Total	**26%**
HCO Payments	$ 280,225,415.00
HCO Lost w/ Fixed-Lost Increase	**$ 7,354,753.00**
HCO Not Lost	$ 272,870,662.00

The impact of the proposed rule is far greater than estimated because CMS has failed to consider the unintended consequences the proposed rule will have on HCOs. The interaction of the increase in the HCO fixed loss threshold and the proposed SSO policy will penalize LTACHs for providing services to the very patients that are most appropriate for LTACH care – the long-stay, high cost patients that become HCOs. This result further calls into question both the purpose and effect of the proposed rule.

3. ALTHA Position and Alternatives

CMS should provide the full market basket update of 3.2% for RY 2008. An increase of less than the market basket will not account for the cost of goods and services required to deliver LTACH services and will result in rates below the cost of care. As proposed, the market basket increase will be offset by a factor that is not relevant to the price of inputs generally or specifically the cost of providing LTACH services in RY 2008. The full market basket update is a more accurate reflection of items and services purchased to treat Medicare beneficiaries and is necessary to account for the rising cost of inputs.

D. One-Time Budget Neutrality Adjustment

1. Summary of Proposal

Under existing rules, CMS provided for the possibility of making a one-time prospective adjustment to the LTACH PPS rates before the end of the transition period (originally October 1, 2006,

now July 1, 2008) to correct any error CMS made in estimating the federal rate in the first year of LTACH PPS. In the proposed rule, CMS delays the decision of whether to exercise the one-time prospective budget neutrality adjustment. CMS asserts that it will have sufficient new data for a comprehensive reevaluation of the FY 2003 budget neutrality calculations after October 1, 2007, the conclusion of the five year transition period. Accordingly, CMS proposes to again consider whether to make a one-time prospective adjustment to the LTACH PPS rates for RY 2009.

2. ALTHA Response

All of the payment adjustments CMS has made to the LTACH PPS since it was effective on October 1, 2002 offset the need for a one-time budget neutrality adjustment. In the preamble to the final rule implementing LTACH PPS, CMS reasoned that the one-time budget neutrality adjustment was necessary to ensure that aggregate payment under LTACH PPS would equal approximately the amount that would have been paid to LTACHs under TEFRA had LTACH PPS not been implemented. The original one-time budget neutrality adjustment regulation provides as follows:

> The Secretary reviews payments under this prospective payment system and may make a one-time prospective adjustment to the long-term care hospital prospective payment system rates by October 1, 2006, so that the effect of any significant difference between actual payments and estimated payments ***for the first year*** of the long-term care hospital prospective payment system is not perpetuated in the prospective payment rates for future years. 67 Fed. Reg. 56052 (August 30, 2002)(codified at 42 C.F.R. § 412.523(d)(3)).

The stated purpose of the one-time adjustment "is to ensure that ultimately, total payments under LTCH PPS are 'budget neutral' to what total payments would have been if the LTCH PPS were not implemented in FY 2003, by correcting for possible significant errors in the calculation of the FY 2003 LTCH PPS standard federal rate." 71 Fed. Reg. 27825 (May 12, 2006). Throughout the rulemaking process, CMS consistently states that the one-time budget neutrality adjustment would only be used to adjust the Federal rate in the event payments under LTCH PPS in FY 2003 differed substantially from payment under TEFRA. See 68 Fed. Reg. 34153 (June 6, 2003)(final annual payment rate update for RY 2004); see also 71 Fed. Reg. 4681 (Jan. 27, 2006)(proposed annual payment rate update for RY 2007).

In postponing the one-time budget neutrality adjustment, CMS claimed that the delay was necessary because of the "time lag in the availability of Medicare data upon which this adjustment would be based." CMS also claimed that the extension of the one-time adjustment would permit the agency the opportunity to review the impact of other adjustment policies. Justifying the extension, CMS stated that:

> [I]t is appropriate to wait for the conclusion of the 5-year transition to 100 percent fully Federal payments under the LTCH PPS, to maximize the availability of data that are reflective of LTCH behavior in response to the implementation of the LTCH PPS to be used to conduct a comprehensive evaluation of the potential payment adjustment policies (such as rural location, DSH and IME) in conjunction with our evaluation of the possibility of making a one-time prospective adjustment to the LTCH prospective payment system rates provided for at § 412.523(d)(3). 71 Fed. Reg. 4680 (January 27, 2006).

Rural location adjustment, disproportionate share payments and indirect medical education payments are not the only policies that have resulted in reducing payments to LTACHs. Since the LTACH PPS began on October 1, 2002, CMS has used a variety of adjustments to the federal rate to reduce payment. In

addition to the existing 25% rule, CMS reweighted the DRGs in October of 2005 reducing rates by 4.2% and again reweighting DRGs in October of 2006 causing a 1.4% reduction in rates. Effective July of 2006, CMS reduced payment to short stay outliers by 3.7% and made no increase in the market basket update. The proposed rule is estimated to further decrease SSO payments by another 0.9%. The cumulative effect of these payment changes has been to bring LTACH margins close to zero. Based upon MedPAC's current margin analysis, CMS is now proposing rates from 3.8% to 5.7% below LTACH providers' cost of care if the proposed rule is finalized in its current form (see Table 2, page 18). Taken together, these adjustments ensure that any difference between actual payments and estimated payments for the first year of LTACH PPS have not perpetuated. There is no need for a one-time budget neutrality adjustment. In our view, the series of adjustments to LTACH PPS rates in recent years offsets any estimated "overpayment" in first year LTACH PPS rates that CMS may feel the need to correct with a one-time adjustment.

3. ALTHA Position and Alternatives

ALTHA agrees that CMS should not make the one-time budget neutrality adjustment at this time, and believes the data supports not making this adjustment in the future. Significant adjustments have been made to LTACH PPS since it was implemented on October 1, 2002. The cumulative effect of these policy changes negates the need to correct any discrepancy between estimated and actual payments in the first year of the LTACH PPS.

E. Budget-Neutral Reweighting of LTC-DRGs

1. Summary of Proposal

Beginning with the LTC-DRG update for FY 2008, CMS proposes to make an annual update to the recalibration of the LTC-DRG relative weights that would have a budget neutral impact so that the estimated aggregate LTACH PPS payments would be unaffected. CMS would update the LTC-DRG weights annually in the IPPS rulemaking and those weights would be modified by a single budget neutrality adjustment factor to ensure that estimated aggregate LTACH payments after reweighting are equal to estimated aggregate LTACH payments before reweighting.

This proposal is based upon CMS's analysis of 2005 and 2006 case mix data showing a 1.9% increase in the case-mix index, which CMS believes is a "real" change due to patient severity, rather than "apparent" due to changes in coding practices.

2. ALTHA Response

ALTHA supports CMS's proposal to establish a budget neutral requirement for the annual reclassification of the LTC-DRGs and recalibration of relative weights. Since the annual re-weighting of DRGs in a budget neutral manner is explicitly designed to redistribute weights in such a way as to address "real" or "apparent" changes in case-mix, ALTHA urges CMS to use budget neutral DRG reweighting, not market basket reductions, to address this issue. To further ensure proper payment for resource intensive cases, CMS should monitor the annual reweighting of LTC-DRGs to determine if the reclassification and recalibration directs payments from high acuity to lower acuity DRGs. Any reweighting of LTC-DRGs should be conducted in a manner that does not result in a redistribution of payments from high acuity DRGs to lower acuity DRGs, pending implementation of revised certification criteria designed to screen out inappropriate cases.

3. ALTHA Position and Alternatives

ALTHA supports this change in policy as a necessary step to bring the LTACH PPS more in line with the IPPS budget neutrality requirements. ALTHA and its members have advocated budget neutral

reweighting in the past. It is also included in the bills before the United States House of Representatives (H.R. 562) and Senate (S. 338).

III. Conclusion

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

Sincerely,

William Walters
Chief Executive Officer

Submitter : **James Blanton** **Date: 03/23/2007**

Organization : **East Texas Specialty Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment A and Exhibit 1.

CMS-1529-P-55-Attach-1.DOC

CMS-1529-P-55-Attach-2.DOC

-#55

March 16, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1529-P
P.O. Box 8015
Baltimore, Maryland 21244-8015

Re: Comments on Medicare Program; 2008 Proposed Update Rule
Published at 72 Federal Register 4776 *et seq.*

Dear Ms. Norwalk,

East Texas Specialty Hospital submits these comments on proposed rules published on February 1, 2007 at 72 *Fed. Reg.* 4776 et seq. This rulemaking seeks to make significant changes to the admission practices of long-term care hospitals (LTCHs) as well as payment policies.

East Texas Specialty Hospital was established on September 30, 1994 and is located at 1000 S. Beckham in Tyler, Texas. It serves a significant percentage of Medicare patients residing in the East Texas area. CMS' proposed expansion of the 25% rule to freestanding and grandfathered hospitals, and its "consideration" of a policy to expand the short stay outlier ("SSO") payment policy to allow "extremely" SSO cases to be paid comparable to IPPS cases, both are unfair and unsupported by facts, and contrary to the clinical and financial data available.

With respect to the proposed expansion of the 25% rule we specifically submit the following:

1. The proposed rule is clearly anti-rural. For example, we submit the attached Exhibit 1 that illustrates the obvious disparity in opportunities between a large urban provider and a regional urban provider that serves a large rural market. As you can see with respect to provider 452015, they are in a large urban area (Dallas, Texas) and located within 25 miles of <u>at least</u> 29 short-term acute care hospitals. Conversely, provider 452051 is located in a smaller urban area (Tyler, Texas) that serves a large rural market. They are located within 25 miles of only 4 providers (only 2 of which have appreciable number of discharges). Twenty nine referral sources versus four referral sources? Could anyone seriously argue that

both hospitals are on an equitable plane when not more than 25% of your admissions can emanate from a single referral source? While the exception for MSA dominant and single urban hospitals is a step toward equality, it still places the smaller urban hospital at a significant disadvantage if there are minimal referral sources. For example, in the Tyler market, the two main hospitals each have approximately 45% of the Medicare discharges, thus provider 452051 is essentially restricted under the proposed rule (with arbitrary payment cuts) if their referrals are not directly even between the two main referral sources. On urban single providers the disparity is completely indefensible with a cap of 50% when there is only one referral source. On the other hand, our large urban hospital in Dallas could conceivably receive referrals equally from only five of the twenty-nine hospitals within a range of 25 miles and safely satisfy the rule. In the name of fairness, if you are going to maintain and expand this rule, at least apply it equally to large urban hospitals, perhaps implementing a % limitation from referral sources not greater than the referral source's % of Medicare discharges in the area. Short of doing this, large urban areas would clearly have an advantage over smaller urban (or rural) areas that have limited providers. Should you not agree with this logic, we would love to hear why discrimination against smaller rural and urban providers is equitable.

2. This proposed rule ignores the realities of how rural healthcare is delivered. Our system currently consists of eleven rural hospitals in East Texas and a single tertiary care hospital in Tyler. The rural hospitals range as far as 100 miles north (to Clarksville), 35 miles west (to Athens), 109 miles south (to Trinity), and 61 miles east (to Carthage). Patients are often treated initially at their local hospital (either in the ER or as an inpatient) but ultimately the need for access to specialized physicians often requires that they be transported to our Tyler location. Under your proposed rules, many of these patients face restricted access simply because their local hospital is unable to provide services that they need. In fact, we noted that over 68% of our admissions to our LTCH in calendar 2006 were to rural residents who live outside of the county in which our hospital is located. It would be interesting to see how that compares to providers in large metropolitan areas like Dallas. Your proposed rule favors residents in large urban areas that have many full service hospitals (provider 452015) over rural residents who reside in limited service hospital markets (provider 452051) – period.
3. While we appreciate your concerns cited in 72FR4809 about the shifting of costly, long stay cases resulting in "a financial windfall for both providers", hasn't that concern been addressed by the acute DRG transfer rule? Sure, in the old days you had cases where a patient was admitted for what turned out to be the old DRG 483 that resulted in a 10-day stay in the acute hospital, along with the full $70,000 DRG payment, followed by a 25 day stay in the LTCH where they received their cost. That is not happening any longer with the expansion of the DRG transfer rule to consist of virtually every meaningful DRG. There is no "windfall" on what is a de facto per diem reimbursement system today.
4. We are always amused as to how you operate under the premise that everyone always knows what DRG every patient falls into in real-time. While it is certainly easy for mathematicians to review data retrospectively and determine what should

have been done, what could have been done, or what might have been done, in real-life it is much more challenging. Take the following example, a patient is admitted to acute care for an infected decubitus ulcer on the heel for a possible DRG 271. An x-ray performed on day two reveals acute osteomyelitis also exists resulting in possible DRG 238. A day or so later a debridement of skin and bone is performed by the physician and we are now looking at DRG 537. Conservative care to salvage the leg is deemed unsuccessful and now requires amputation resulting in DRG 217. The operative report by the surgeon concludes the patient had a diabetic ulcer and osteomyelitis and a final DRG 113 – as long as the attending physician agrees (sometimes they do, sometimes they don't). This happens all the time. DRG assignment is a function of physician documentation (an opinion), clinician documentation (an opinion), clerical competence (for example, a lab report misfiled), coder expertise (and opinions), and sometimes even the date of the discharge (September 30 versus October 1). Often the DRG can change based on the physicians discharge summary after the patient is gone. It's complicated in the real world.

As a result, trying to predict whether a patient might or might not be in outlier status in real-time is virtually impossible except in the most obvious of cases (a 100 day stay for example). In addition, with the recent changes in the outlier policy to consist of retro-settlement in certain situations, would cases that were in outlier at the time of service, but determined to not be in outlier status at a later date qualify? What about subsequent changes by the PRO that alters DRGs and possibly outlier status? Would there be some incentive for "down-coding" of DRGs that result in increased outliers in some cases? What about up-coding that results in a case that is should be in outlier status but isn't? What about the timing of changes in the cost-to-charge ratio at the fiscal intermediary (it's an outlier on the day before the cost-to-charge ratio is updated, but not on the day after). One could almost ask the question, when is an outlier really an outlier. This just illustrates the problem with a rule (25%) rule that is oriented to only where a patient comes from and not what a patient needs.

We would suggest that you reference back to 72FR4805 and subscribe to what you wrote when you say "(W)e continue to believe that in defining a LTCH as a hospital with an inpatient ALOS of greater than 25 days in section 1886(d)(1)(B)(iv)(I) of the Act, that the Congress was focusing on the LOS as the **essential characteristic** (emphasis added) of this provider category."

With respect to the proposed revisions to the short-stay outlier policy, we submit the following comments:

1. We appreciate your concerns on inappropriate patients being admitted to LTCHs and the need for special payment provisions for genuinely short-stay cases. However, proposing payment cuts on patients that even exceed the statutory requirement for LTCH status seems to be incongruent. For example, when I look at the "FY 2007 LTC-DRG Table, including 'IPPS Threshold'" on the www.cms.gov website, I note that there are 9 DRG's that the "IPPS

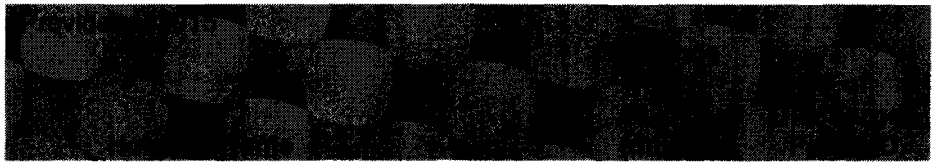
> Threshold" exceeds 25 days. It seems to be a weak argument to have genuinely long-stay cases and still be subject to payment cuts under the implication that these patients are somehow unsuitable for admission to a LTCH. For example, if we admit a patient who results in DRG 541 and they stay 65 days, I am paid at the IPPS rate because that suggests "general acute treatment is being provided" (72FR4807). On the other hand, another provider could admit a patient who falls into DRG 113 and they stay for 21 days, and they receive a full LTCH payment because this does not suggest "general acute treatment is being provided"? Does this make sense? Under what logic? We think at a minimum that any case that exceeds the statutory ALOS requirement should not be tainted with some insinuation that it was somehow an inappropriate admission.

In view of the above comments, East Texas Specialty Hospital urges you not to expand the 25% rule or the short-stay outlier policy in long-term care hospitals.

Sincerely,

James M. Blanton, CPA
Director of Finance

Exhibit 1
Comparison of Medicare Provider 452015 and 452051
Short-Term Acute Hospitals Located within 25 Miles of LTCH



Medical City	Dallas	1.9	24,747
Presbyterian	Dallas	1.9	33,535
Baylor Regional at Garland	Garland	5.9	10,662
Doctors Hospital	Dallas	7.1	7,601
Richardson Regional	Richardson	7.3	6,277
RHD Memorial	Dallas	8.8	4,116
Medical Center of Plano	Plano	9.2	16,426
Baylor Regional at Plano	Plano	10.1	3,623
Baylor	Dallas	10.2	41,664
UT Southwestern Zale Lipshy	Dallas	11.3	5,402
UT Southwestern ST. Paul	Dallas	11.5	10,972
Mesquite Community Hospital	Mesquite	12.1	8,633
Parkland	Dallas	13.5	55,628
Methodist Dallas	Dallas	13.9	18,350
Medical Center of Mesquite	Mesquite	14.2	8,482
Presbyterian of Plano	Plano	14.3	13,959
Las Colinas Medical Center	Irving	14.4	3,591
Irving Coppell Surgical	Irving	14.4	196

ETMC Tyler	Tyler	-	21,864
Mother Frances	Tyler	0.2	20,966
Texas Spine and Joint	Tyler	1.2	1,394
U.T. Health Center	Tyler	8.4	2,901

Lake Pointe Medical Center	Rowlett	14.6	5,754
Trinity Medical Center	Carrollton	16.6	7,721
Baylor Medical Center	Irving	18.1	12,986
Presbyterian of Allen	Allen	19.1	2,620
Baylor Medical Center	Frisco	19.2	733
Medical Center of McKinney	McKinney	20.7	9,125
Centennial Medical Center	Frisco	21.1	2,805
Medical Center of Lewisville	Lewisville	22.6	10,519
Methodist Charlton	Dallas	22.7	12,373
Baylor Regional Grapevine	Grapevine	23.5	11,568
Medical Center at Lancaster	Lancaster	24.9	3,160

Submitter : Ms. Lynda Payton **Date:** 03/23/2007

Organization : The Nebraska Medical Center

Category : Hospital

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

See Attached Document

CMS-1529-P-56-Attach-1.DOC

#56

SENT ELECTRONICALLY ON March 23, 2007

March 23, 2007

The Honorable Mark B. McClellan
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: CMS-1529-Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes; Proposed Rule

Dear Dr. McClellan:

The Nebraska Medical Center appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule establishing new policies for Hospital Direct and Indirect Graduate Medical Education.

The Nebraska Medical Center is a 687-licensed medical/surgical bed acute care teaching hospital located in Omaha, Nebraska. As a provider of Medicare services, we are always concerned about any significant revisions to the IME and GME Regulations.

Payment for Direct Graduate Medical Education

Although we appreciate the quantification of "substantially all" costs at 90% of the resident's salary and physician supervisory time, we do not agree with the proposed computation of the physician's salary for supervisory time or that CMS feels that they need to dictate the amount a hospital pays a physician for supervisory time.

First and foremost CMS needs to realize that the payment made to physicians at non-hospital sites for supervisory time needs to be established by the physician and the teaching hospital/medical school. If a physician does not feel they are being reasonably compensated for their time, they will not provide the services required to train the residents at their location. This fact alone negates the need for CMS to dictate a specific payment amount that hospitals/medical schools must make for "Supervising Physicians". Secondly, CMS needs to understand the difference between a true non-hospital site and a clinic in which physicians associated with the medical school and/or the teaching hospital are training the residents. In most situations, a large teaching hospital will have an affiliation with the medical school and a physician group will also be involved in the relationship. In this type of situation, there are agreements between the hospital, the school and the physician group. The residents will spend most of their non-hospital time (continuity clinics etc.) with this one physician group. The residents will most likely visits multiple clinics for various increments of time. In a true non-hospital site, the physician will have no relationship with the medical school but may have privileges at the hospital. In this situation the resident will usually spend a specified amount of time (i.e. a week, a month etc.) with this physician.

As these situations are very different in nature, the contract/agreement requirements for each type of relationship need to be addressed differently. In most situations where there is training with a physician group associated with the medical school and/or hospital, there is usually a global agreement. In the

proposed rule, a global agreement would need to separate out each clinic and provide a breakout of resident's salaries and physician compensation at each clinic. The purpose of this proposed rule is to decrease the administrative burden however, by requiring a breakout the administrative burden would be greatly increased.

We also take issue on how CMS is determining "Supervisory Time". In the proposed rule CMS is assuming that no matter how much time a resident is at a non-hospital site, the physician will spend approximately 3 hours of supervisory time on that resident. If a resident is at the non-hospital site 1 hour a day for a week or all day everyday for a week, the physician compensation will be computed based on three hours of supervisory time. This is not fair; if this is the route CMS chooses to take, the supervisory time should be reduced to reflect the actual time a resident is spending at the non-hospital site. For example if the clinic is open 8 hours a day 5 days a week, then the physician compensation for a resident who spends 1 hour a day there should be based on 4 hours of resident time /40 hours clinic is open x 3 hours of physician time for a full week. This would result in .3 hours of physician time for a resident that spent 4 hours at the clinic and 3 hours for the resident that spent the entire week there. We also feel that as opposed to the National Average Physician Salary Data, the reasonable compensation equivalents (RCEs) should be used to as the source for the physician salary data source.

Requiring the hospital to have an agreement outlining the actual payment to be made for resident's salaries and physician compensation prior to the beginning of the assignment is unrealistic for most situations. A resident's schedule is prepared ahead of time, but there may be changes to the rotations or clinics throughout the year or residents may drop out of the program. This is especially burdensome for those rotations to affiliated physician group clinics, as there are multiple residents rotating to multiple clinics at any given time. CMS needs to recognize the use of a global agreement in this type of situation without requiring a specific breakout in writing prior to the training. A global agreement is the only way to reasonably address these types of situations and the proposed rule is requiring a change that is not feasible to most institutions.

I would like to take this opportunity to thank CMS for allowing The Nebraska Medical Center to comment on these very important issues. If you should have any additional questions or need additional information, please feel free to contact me at (402) 559-3555 or lpayton@nebraskamed.com.

Sincerely,

Lynda Payton
Senior Reimbursement Analyst
The Nebraska Medical Center

Submitter : **Dr. Daniel Sontheimer** **Date: 03/23/2007**

Organization : **Cox Health, Family Medicine Residency**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

The proposed rule for teaching and payments in non-hospital sites is one of the most honerous and incredibly difficult ideas. In family medicine, we already use a great number of our non-hospital sites, this will make it more difficult as the payments require:

1. Us to dig into the hours worked, and salaries/income of private faculty, which is not a welcome intrustion to them.
2. Try to separate direct patient care from teaching time, when in fact well over 99% of the time is patient care by the private faculty with the resident learning by observation. There is next to nothing if formal lecturing, we separate that out from clinical time in our program.
3. Financing education is hard enough, but with Medicare and Medicaid being the only GME payors, which I think is not fair, the Balance Budget Act has led to declining or frozen payments while operating costs continue to increase.
4. People volunteer with good will and no expectation of payment, part of the Hippocratic tradition, why can't that be left alone?

Submitter : **Ellen Smith** **Date: 03/23/2007**

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

Category : **Health Care Professional or Association**

Issue Areas/Comments

Background

Background

"see attachment"

GENERAL

GENERAL

"see attachment"

Impact

Impact

"see attachment"

LTC-DRG Classifications and Relative Weights

LTC-DRG Classifications and Relative Weights

"see attachment"

Other Proposed Policy Changes For The 2008 LTCh PPS Rate

Other Proposed Policy Changes For The 2008 LTCh PPS Rate

"see attachment"

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

"see attachment"

CMS-1529-P-58-Attach-1.PDF

#58

Dubuis
Health System

System Office

10333 Richmond Ave.

Suite 300

Houston, TX 77042

713/339-7000

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Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1529-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Comments on Medicare Program; 2008 Proposed Update Rule
Published at 72 Federal Register 4776 *et seq.*

Dear Ms. Norwalk:

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

Let me begin by expressing my appreciation for CMS' proposal for a 0.71 percent update to the LTCH standard rate. While I believe the full 3.2 percent update would have been more appropriate and I question whether CMS is overestimating the percentage of cost increases contributable to coding practices, I applaud CMS for its efforts to at least partially adjust reimbursements to account for increased costs. I also applaud CMS' proposal to require budget neutrality in future LTCH-DRG updates and relative weights adjustments. As you know, industry leaders as well as the Medicare Payment Advisory Committee have supported such a position for the past several years. I am pleased that CMS has come to agree that such a budget neutrality requirement is appropriate.

However, I continue to strenuously oppose the expansion of CMS' arbitrary admission restrictions that completely ignores the medical needs of patients and threatens to destroy the viability of the LTCH industry. I am specifically referring to the expansion of the 25 percent admissions cap to freestanding and grandfathered LTCHs and the further expansion of the short stay outlier policy. I will address these issues more specifically later in these comments. First, however, I would like to address CMS' baseless assumption that LTCHs provide no benefit other than to allow acute care hospitals to cheat the IPPS payment system.

LTCHs are designed to provide acute care services to those severely ill patients that require more time and detail than can reasonably be expected in an acute care hospital. Often, LTCH patients feature co-morbidities and require extensive treatment. LTCHs can offer the specialized, team-based care needed for complete long-term recovery. LTCHs are often successful in recovering a patient's full physical and cognitive abilities leaving then with a better quality of life and a reduced risk of re-admittance for the same condition. Admissions to an LTCH are based upon the recommendations of the treating physician who is in the best position to judge the benefits and timing of a patient's transfer to an LTCH. CMS' policies inexplicably usurp the medical judgment of physicians in favor of a purely bureaucratic admission standard that completely ignores the medical needs of the patient. In the proposed rule, CMS levels astounding accusations that hospital executives are conspiring to dictate the timing of patient discharges in order to circumvent the IPPS payment system. If this is indeed the case, I challenge you to offer proof and validation of such accusations. I would further suggest the proper course of action in such an instance would be to take corrective measures against the bad actors, rather than cast a wide net that threatens the ability of the entire LTCH system to provide quality care to their patients.

An examination of referral patterns is not an appropriate justification for these accusations. Naturally, a healthcare professional is going to refer patients to the facility that is most convenient for the patient, provided that facility is capable of meeting the patient's health needs. In most cases, the facility most convenient for the patient will be the facility closest to the location from which the patient is being transferred. A shorter transfer minimizes health risks during transfer and provides the least disruption for the patient, their family, and their course of treatment. High referral patterns from a single source may indicate geographic proximity to the referral source, or a lack of other LTCHs in the immediate area, rather than a conspiracy to cheat the Medicare system. To the best of my knowledge, CMS' analysis fails to take these, or any other, possibilities into account.

Any concerns CMS has about proper LTCH admissions would be addressed through the establishment of patient and facility level admissions criteria. However, inexplicably, CMS has taken no tangible steps toward this end despite the strong recommendations of Congress, MedPAC, and industry leaders.

<u>Establishing a 25 percent admission cap for all LTCHs</u>

I would like to express my strong opposition to any further expansion of the 25 percent admissions cap on Long-Term Acute Care Hospitals (LTCHs), as outlined in CMS' proposed LTCH PPS rule. First of all, allow me to assure you that Dubuis fully understands the concerns CMS has expressed that there may be inappropriate admissions of some LTCH patients.

Dubuis Health System hospitals only accept patients who are pre-screened by an interdisciplinary team to determine that admission criteria are met. We worked hard for several years to develop criteria that would ensure that our hospitals make appropriate admissions decisions. Our criteria served as the template for those later refined and adopted by the National Association of Long Term Hospitals (NALTH). In a recent analysis of referral and admission patterns in our hospitals-within-hospitals, we found that less than half of the patients referred to our facilities are actually admitted. Of those patients not admitted, an astonishing 68% were denied admission by our interdisciplinary team because they did not meet our stringent clinical criteria. In comparing "denial rates" between host hospital and outside referral sources (other acute providers), we found no significant difference. However, not all LTCHs use the same criteria. In fact, anecdotally it appears that some do not even require an acute hospital level of care. On many occasions we have denied admission to patients who, as judged by our interdisciplinary team, do not require a hospital level of care. As part of our "denial" process, we often document in the patient's chart a recommendation to refer the patient to SNF or even home with home health. Nonetheless, we will later be informed that the patient was subsequently admitted to a competitor LTCH.

While I understand CMS' concerns regarding improper LTCH admissions, further expansion of the cap to freestanding and grandfathered LTCHs would only jeopardize the treatment of legitimate LTCH patients. The 25 percent rule is bad policy that is based upon unjustifiable assumptions and fails to address the concerns CMS' claims it corrects. Expanding this bad policy to freestanding and grandfathered LTCHs will further erode the industry's ability to provide specialized care to medically-deserving patients. A patient's post-acute care placement should be determined solely by medical considerations, and not by indiscriminate thresholds placed on potential referral sources. Applying the 25 percent threshold to freestanding and grandfathered LTCHs would take post-acute care decisions out of the hands of physicians and could severely jeopardize the treatment of otherwise appropriate LTCH patients.

Revised Short Stay Outlier Policy

In the RY 07 final rule, CMS established a change in the payment methodology for short stay outliers. The new methodology removes any financial incentives for admitting short stay outliers and admirably attempts to provide reimbursement that match increasing costs throughout the stay. However, the additional revisions proposed in the RY 08 rule establishes severe financial penalties for those patients meeting the definition of what I will refer to as a "very short stay outlier" (LOS less than or equal to the average LOS plus one standard deviation assigned to the same DRG under the acute hospital IPPS DRG system). CMS infers that every case of a very short stay outlier results from nefarious intentions

and makes no effort to consider other uncontrollable reasons for very short stay status. Again, if CMS has any evidence or justification for such an accusation, I encourage you to share that information publicly and take appropriate action against the offending parties.

In the case of Dubuis, we reviewed our cases that would meet the proposed definition of very short stay outlier. While they were a relatively low percentage of our total Medicare discharges, we determined that approximately 50 percent of our very short stay outliers were discharged as a result of death. LTCHs admit some of the most complicated medical cases. Unfortunately, in some cases, death can occur unexpectedly. While it may not be appropriate for these cases to receive a full LTCH payment, it is equally inappropriate to assume sinister intent and level a financial penalty on an LTCH operating in good faith. Otherwise, I would be interested in receiving guidance from CMS as to how an LTCH is expected to determine the likelihood of premature death and how any healthcare provider can ethically refuse specialized care based upon the potential of death.

Other than death, very short stay outliers could be caused by such things as the patient's choice to be transferred to another facility or refuse further treatment against medical advice. In addition, despite a LTCHs best attempt to estimate a course of treatment, some patients just progress more quickly or slowly than anticipated. Again, an LTCH should not be subject to financial penalties when acting in good faith. The proposed very short stay outlier provision again fails to give any consideration to the medical needs of beneficiaries and casts a far too wide net to address concerns derived from unjustified and unsubstantiated assumptions. Once again, I will note that CMS' concerns **would** be appropriately addressed through the development of medically-based patient and facility admissions criteria.

Effect on Potential Legislative Action

As you may be aware, legislation has been introduced in both houses of Congress to address the implementation of facility and patient criteria for LTCH admissions. I am optimistic that this Congress will move forward on criteria and elimninate the need for the 25 percent rule and some of CMS' other arbitrary policies. Finalizing the expansion of the 25 percent rule and very short stay outlier policy would provide little benefit to Medicare beneficiaries and would only create additional financial burdens that would need to be addressed in future legislation. I am concerned that implementation of these policies would serve only to further damage the industry's ability to provide essential medical care to severely ill beneficiaries. In addition, implementation of these provisions could slow the encouraging progress that is being made towards admissions criteria that would guarantee appropriate admissions to LTCHs based solely upon the medical needs of beneficiaries. Given the numerous concerns that have been raised by patients and healthcare providers alike, and the long-term effects these

reforms will have on the post-acute care system, these issues would be better addressed comprehensively through the legislative process.

Therefore, I strongly encourage you to eliminate the expansion of the 25 percent rule to freestanding and grandfathered LTCHs, and the proposed very short stay outlier policy, when the LTCH PPS rule is finalized. I also strongly encourage you to work with Congress and industry leaders in establishing and implementing medically-based patient and facility admissions criteria.

Again, I appreciate the opportunity to comment on these critical policy concerns. As always, Dubuis stands ready to work with CMS in properly addressing any issue they may have with the LTCH industry. Please do not hesitate to call on us if we may be of assistance.

Sincerely,

Ellen Smith
Chief Executive Officer
Dubuis Health System

Submitter : Mr. Michael Pelc **Date:** 03/23/2007

Organization : Detroit Medical Center

Category : Hospital

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

See attachment

CMS-1529-P-59-Attach-1.DOC

#59

DMC
DETROIT MEDICAL CENTER

March 26, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1529-P
P.O. Box 8015
Baltimore, Maryland 21244-8015

RE: CMS-1529-P – Proposed Rules on Changes to the Policies for Receiving Medicare DGME/IME payments for Residents Training at Non-hospital Sites (Vol. 72 No.21) February 1, 2007

The Detroit Medical Center – and its affiliated hospitals: Children's Hospital of Michigan, Detroit Receiving Hospital, Harper-Hutzel Hospital, Huron Valley-Sinai Hospital, Rehabilitation Institute of Michigan and Sinai-Grace Hospital – operate as a private non-profit health care delivery system in the Detroit, Michigan area.

We appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule.

The Detroit Medical Center (DMC) hospitals are affiliated with Wayne State University (WSU) School of Medicine and have a large GME Program with 900 resident FTEs. Over the course of a year approximately 600 residents receive training at 127 non-hospital sites for rotations that typically last for one month at a time. This results in approximately 30 to 40 FTEs per cost report period. The residents are in different Program Years (PGYs), and different specialty programs, who train at the same non-hospital site at the same time. These non-hospital sites are open, on average, approximately 45 hours per week

MAJOR RECOMMENDATION:
ADMINISTRATIVE BURDEN – Definition of "Substantially All"
This proposed rule is a tremendous administrative burden to the DMC and WSU resident training program due to our large number of non-hospital based rotations.

The DMC strongly recommends that CMS remove this administrative burden by implementing what Congress intended, effective July 1, 1987 and January 1, 1999 – that hospitals count residents in non-hospital sites for direct GME and IME purposes if the hospitals incurred 'substantially all the costs' for the residents only.

The intent of Congress was to encourage GME programs to train residents in non-hospital sites. CMS, through these proposed and current regulations, is placing a huge administrative burden on teaching hospitals by being concerned about how much teaching physicians are compensated for the non-hospital training.

This entire regulation can be simplified if the definition of 'substantially all the costs' be defined as the hospitals incurring 100% of the residents costs only while training in the non-hospital based sites.

This simplification would be mutually beneficial to teaching hospitals and CMS. It would result in simplified intermediary audits of the non-hospital based site resident FTEs.

The DMC also recommends that the above change in definition be made retroactive to January 1, 1999.

OTHER RECOMMENDATIONS:
If the above major recommendation was adopted by CMS the following recommendations would not be necessary to the proposed regulations.

THREE-HOUR PRESUMPTION

The nature of training at non-hospital sites is hands-on training during the course of patient encounters. Indeed, the *raison d'etre* for rotating residents to these sites is to give residents exposure to patients with a broader range of, or different problems than are seen in other settings. Didactic training almost always occurs in the hospital or in an affiliated medical school. Thus, the amount of time that a supervising physician spends on teaching residents, as that term is defined by CMS, is typically very low.

CMS has not furnished the data that it is relying upon to create the three-hour presumption, and thus, it is impossible to submit informed comments on that data. Even by CMS's description, however, the evidence for the three-hour presumption is thin, and a rule should be based on good data. Accordingly, we recommend that CMS commission a study that gathers data from a sufficient number of representative sites so that this rule can be modified in the future to reflect more accurately teaching time actually occurring in non-hospital sites.

The preamble to the rule states that the three hours per week proxy will be prorated; yet we are informed that CMS has orally informed AAMC that there will be a presumption of three hours of teaching time a week without regard to how long a resident is at the non-hospital site. For example if 20 residents rotated through a site with a single employed physician, with each resident's rotation for half a day, we understand that the three-hour proxy is being interpreted by CMS as imputing 60 hours of teaching time—three hours per resident. On its face, this is an absurd result, if it is a correct understanding of CMS policy that has only been communicated orally. We remain

unclear on how CMS actually intends to apply its policy and what we have heard second hand differs from what is said in the preamble to the rule. Accordingly, we believe that CMS should issue an interim final rule explaining in detail how it proposes to count the three-hour proxy and soliciting comments on that approach. Incidentally, it is not uncommon that a resident spends less than a full week at a site.

USE OF ACTUAL TIME

CMS expressly permits hospitals to use the actual time spent teaching in non-hospital sites to compute the costs of that teaching. The preamble to the 1998 rulemaking indicated that whatever reasonable amount was agreed upon by the non-hospital site and the hospital would be accepted as reflecting the costs of the non-hospital site. In practice, CMS and intermediaries have departed from this standard, and in oral presentations, CMS personnel have suggested that there should be time studies for supervising physicians in non-hospital sites to support the amount paid for that time. While we believe that CMS should stand by its 1998 statements, if it is not going to, it should elaborate on what documentation it wants to support how the amounts paid for teaching time were agreed upon.

DOCUMENTATION THAT NOT ALL PHYSICIANS AT A SITE SUPERVISE RESIDENTS

In the proposed rulemaking, CMS observes that the maximum presumed ratio of teaching physicians to residents is 1:1, but also says that it can be lower if some physicians at the site do not engage in supervising residents. What documentation will be needed to demonstrate which physicians at a site do not engage in teaching? Please also confirm that there is no reason why that documentation cannot be obtained after the resident rotation(s) have occurred.

VOLUNTEER SUPERVISING PHYSICIANS

There are physicians in group practices or at clinic sites who volunteer to train residents and their employer/group practice incurs no expense for that teaching time. Although CMS's published statements in 1998 suggested that there could be volunteer physicians for whom there were no costs that a hospital had to pay in order to count residents in a non-hospital site, CMS's more recent policy has presumed that it is impossible for a employed physician to volunteer his or her time. This is factually and logically incorrect.

As we understand CMS's view, the employer pays a physician for time to be at the employer's site, and the compensation costs paid to the physician should be equally allocated to every minute of the time that the physician is on site. Under the labor law, however, physicians are "exempt" from wage and hourly rules. Thus, they can be paid fixed compensation without regard to hours worked. There is absolutely no reason why the physician and the physician's employer could not agree that the physician's teaching responsibilities are undertaken voluntarily by the physician, do not lessen the physician's

duties to the employer, and involve time in addition to the time that is necessary for the physician to meet fully his or her responsibilities to the employer.

As exempt employees, physicians' hours are flexible. But even under a system with a set number of hours, an employer and employee can agree that volunteer services can be performed during the business day. The rules applicable to government employers recognize that volunteer time, even in the course of usual business hours, is *not* compensated by the government. http://www.opm.gov/oca/leave/html/Volunteer2.asp. Yet CMS refuses to acknowledge that private employers could have the same policies.

CMS should revert to the policy of permitting volunteer physician services as mentioned in the 1998 preamble and program memorandum. CMS should set forth clearly the documentation it would like to see to support that supervising physician time spent teaching is, in fact, volunteer time at no cost to the employer.

CMS's position is that there are no voluntary teaching physicians. Many physicians are willing to donate their time to training residents regardless if they are sole practitioners or in a group practice. CMS, however, is unwilling to allow them to do so. In adopting this policy CMS is driving up the cost of the GME program by forcing institutions to pay physicians for voluntary teaching time. This is contrary to Medicare's "prudent buyer concept," HIM-15, Section 2103, which states:

> *"**PRUDENT BUYER A. General**.--The prudent and cost conscious buyer not only refuses to pay more than the going price for an item or service, he/she also seeks to economize by minimizing cost...Another way to minimize cost is to obtain free replacements...Any alert and cost conscious buyer seeks such advantages, and it is expected that Medicare providers of services will also seek them."*

In reality, this proposed ruling will not only increase GME program costs, but also place a greater burden on the institutions administering GME programs in terms of the time and resources necessary to meet the new requirements.

PROXY PHYSICIAN COMPENSATION AMOUNTS

CMS Should Use Its Own RCEs as the Proxy for Physician Compensation

CMS has solicited comments on what data should be used as a proxy for actual physician compensation. We are surprised that CMS went afield to seek out data on physician compensation costs since it has for more than twenty years vehemently defended the fairness of the amounts set forth in CMS's own "reasonable compensation equivalent" ("RCE") limitations. In 1982, Congress amended the statute to direct the Secretary to reimburse only those physician compensation amounts as are "reasonable," and directed the Secretary to create "reasonable compensation equivalent" ("RCE") limitations for physician compensation costs. The RCEs were created in 1983 and have been applied by CMS since then as its measure of the reasonableness of physician

compensation. Since CMS first established RCE limitations 24 years ago, it has directed its intermediaries to apply those limitations (as updated) from then to the present. 42 C.F.R. § 415.70, *see* 48 Fed. Reg. 8903 (March 2, 1983).

The RCEs are not of historic importance only; they continue to apply to all cost reimbursed services including all services furnished by critical access hospitals and organ acquisition costs in transplant center hospitals. (Virtually all transplant centers are also teaching hospitals.)

For purposes of cost reimbursement, CMS will not allow physician compensation in excess of the RCEs. If CMS used the AMGA data cited in its proposed rule as its proxy for the amount of costs in non-hospital sites, its proxy data would *substantially exceed* the amounts that would be treated as an allowable, reasonable cost under the RCEs. For example, the table showing AMGA's data in the proposed rule reports median compensation for a cardiologist at $363,081. Under the RCEs, however, the maximum allowable compensation for a cardiologist would be somewhere between $150,200 and $165,600, 68 Fed. Reg. 45346, 45459 (Aug. 1, 2003), depending on the geographical area where the cardiologist practices.[1] In short, for cardiologists, CMS proposes to require payment of amounts that are *more than* double the amounts it will allow as "reasonable" costs. In all instances, the AMGA data substantially exceed the RCE amounts. Moreover, this is not a case of comparing two different parts of the regulatory scheme – costs incurred by teaching hospitals for supervising physicians in non-hospital sites are properly reported in the interns and residents cost center on a teaching hospital's cost report and are subject to the RCEs.

If CMS uses any physician compensation data higher than the RCEs (including actual physician compensation), it is requiring hospitals to pay amounts that CMS categorically characterizes as unreasonable and unallowable. Using physician compensation data for amounts that must be paid in order to count residents in non-hospital sites that are inconsistent and higher than CMS's limitations on reasonable cost for physician compensation would be "arbitrary and capricious."

CMS Should Use the Median, Not the Mean of Whatever Compensation Data It Uses.

For purposes of estimating prevailing levels of costs, CMS has consistently used the median, not the mean. For example, "customary" charges under the reasonable charge formula were set at the median of actual charges. The "Section 223" limitations were based upon median costs. The closest analogy is the RCEs since they relate to physician compensation, and the RCEs are based on the 50th percentile, i.e., the median, of physician compensation. To the extent that CMS opts to use physician compensation data other than the RCEs, it should follow its precedent of using the 50th percentile of reported data. In statistics, the standard deviation is measured from the median and the median is much more commonly used for purposes such as estimating prevailing costs.

[1] Under the RCE methodology, all subspecialties of internal medicine use the internal medicine RCE amount.

GLOBAL TEACHING PHYSICIAN COMPENSATION WITH MEDICAL SCHOOLS

The DMC has a global agreement with the Wayne State University School of Medicine (WSU) to provide teaching physicians to train residents in the DMC hospitals and non-hospital based sites. This agreement provides compensation to WSU for teaching physician services.

The DMC recommends that CMS recognize the global teaching physician agreement for all non-hospital based sites that have faculty teaching physicians.

PRESUMED TOTAL HOURS

As CMS notes in the preamble to the proposed rule, whatever number of hours is presumed to relate to training residents, the other number needed to compute the percentage of total physician compensation that time represents is total time.[2] CMS expresses concern determining total time by physician would require time records, which would be counterproductive to achieving the goal of simplification. Therefore, CMS has proposed to use the number of hours that a non-hospital site is open as the "denominator" to match with the "numerator" of three hours. This is a very rough proxy and we believe that it is inaccurate. As just one example, it would yield a clearly inaccurate result for an urgent care center that might be open 60 to 80 hours a week even no individual supervising physician is there all the hours the site is open. Similar anomalous results would occur for clinics open a day or half a day a week (particularly in light of the apparent CMS interpretation that there is a presumption of three hours of training a week per site regardless of how little time residents spend at the site).

CMS has data on physician hours in a study which was the basis for the RCEs, a copy of which is enclosed. That study shows average physician hours *worked* in the "total" category (i.e., all categories aggregated) ranging from 2,284 to 2424.7.[3] (See p. 9 of enclosed study.) Hours worked per week engaged, in part, in training residents cannot properly be computed by dividing those total worked hours by 52 weeks. Instead, 52 weeks needs to be reduced by 10 federal holidays and time off for vacation and sickness, which we assume to be four weeks. Thus, CMS's data that is the basis for the RCEs that are currently being applied shows a range of physician hours worked per week of 49.65 to 52.71 hours. If CMS is using a proxy for physician compensation and a proxy for time spent training residents, it should also use a proxy for hours worked by supervising physician. Based on CMS's own data, data which is part of the RCE limitations that are currently being applied, supervising physicians should be assumed to work 51 hours a week.

If CMS believes that the hourly data that it continues to rely upon for its RCEs is not accurate, the best course of action would be to use that data for an interim final rule,

[2] This assumes that the physician is indeed compensated for his or her teaching time and is not volunteering, as discussed above.

[3] The range of hours reflects rural, small metropolitan, and large metropolitan areas.

obtain better data subsequently, and to refine its rule, if necessary, after it has gotten better data.

If a proxy is used for the time spent training residents and a proxy is used for total physician hours, there is no need to use hours at all. Instead the hours of presumed training time and the total hours can be eliminated from the formula and a single percentage, a proxy percentage of physician time spent teaching, substituted in their place. Thus, we think a formula should be:

Physician compensation proxy using the RCEs

X Percentage of business days in year when resident is at site

X Percentage of presumed training time [number of proxy hours/51 hours]

= Physician compensation attributable to training

TRAVEL AND LODGING

CMS has repeatedly referred to "travel and lodging" expenses in its regulation. We have no objection, in principle, to counting those items as costs. The teaching hospital community presumes, however, that CMS is referring to "travel and lodging" expenses as those terms are usually understood. Hospitals do not typically pay the full rent costs for residents for time that they rotate to the hospital. Similarly, hospitals do not pay ordinary commuting expenses incurred by residents commuting to the hospital. In instances when the resident is assigned to a non-hospital site that is adjacent to the hospital or nearby, we assume that CMS is not asserting that costs to be included in the "substantially all" formula extend to the resident's rent and commuting expenses.

Making assumptions, however, can be dangerous. Accordingly, we request CMS to confirm the validity of this assumption. We also request that CMS address when travel and lodging expenses will be counted as a cost. A simple approach would be to count such expenses as a cost when the resident is assigned to a location that is beyond a reasonable daily commuting distance.

Please contact me at (313) 578-2820 should you have any comments or questions regarding these issues.

Sincerely,

Michael A. Pelc
Vice President, Finance
Reimbursement

Submitter : Dr. Mary Ann Clemens **Date:** 03/23/2007

Organization : Advocate Health Care

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1529-P-60-Attach-1.DOC

#60

Advocate Health Care
205 W. Touhy Avenue, Suite 117
Park Ridge, IL 60068

Medical Education & Research

MEMORANDUM

To: Centers for Medicare and Medicaid Services
Department of Health and Human Services
www.cms.hhs.gov/eRulemaking/

From: Advocate Executive Medical Education Council
Ann Errichetti, MD
Chief Academic Officer

Mary Ann Clemens, EdD Mary Ann Clemens
Vice President, Medical Education and Research

Date: March 23, 2007

Re: Advocate Health Care's Response to "Proposed Rule on Changes to the Policies for Receiving Medicare DGME/IME Payments for Residents Training at Non-hospital Sites" published February 1, 2007 (72 Fed. Reg. 4776)

File Code CMS-1529

We thank you for the opportunity to respond to "Proposed Rule on Changes to the Policies for Receiving Medicare DGME/IME Payments for Residents Training at Non-hospital Sites."

The following response represents the Medical Education leadership of Advocate Christ Medical Center, Advocate Illinois Masonic Medical Center, and Advocate Lutheran General Hospital and our reimbursement officer. Our position is in alignment with the Association of American Medical Colleges (AAMC.)

Definition of "All or Substantially All" (pp. 4820-22)

In essence, the proposed rules establishes a new definition for "all or substantially all of the costs for the training program in the non hospital setting" at 42 C.F.R. §413/75 (b). This definitional change includes moving from the current regulation that requires hospitals to incur the costs of the physician salaries and fringe benefits to incurring only the supervisory physician's salary that is "attributable to direct GME." This means the time that the supervising physician devotes to non-billable GME activities. Examples of

these activities include conferences, practice management, lectures, and teaching duties like resident evaluations. Hospitals would need to incur only 90 percent of the total non-hospital costs in order to be in compliance with the regulation. If the residents' stipends and benefits comprise 90 percent of the total costs, the hospital need not pay any supervisory costs. If the residents' stipends and benefits comprise less than 90 percent of the total, the hospital would only have to pay a supervisory cost amount that would result in the combined stipends and benefits plus supervisory costs totaling 90 percent.

Advocate: *We appreciate the reduction in the "substantially all" cost threshold, but it should be reduced further than 90%.*

Physician Supervisory Costs (pp. 4824-25)

- **Solo Practitioners**

According to the document, there are no supervisory costs associated with solo practitioners because their total compensation is "based solely and directly on the number of patients treated and for which he or she bills." When the solo practitioner is not treating patients and is engaged in didactic activities with residents, he/she receives no compensation. Therefore, there are no direct GME supervisory costs that the hospital must incur in order to qualify for Medicare DGME or IME payments.

Advocate: *If the group practice can demonstrate that a physician's supervision activities were not a factor in the determination of his/her salary, then there are no supervising costs under the Medicare definition and the hospital does not need to pay any.*

- **Group Practices**

According to CMS, whether there are supervisory costs associate with a physician group practice depends upon whether the physicians are receiving a "predetermined payment amount, such as a salary." This predetermined amount, according to CMS, is not based on patient volume and reflects all of the physician's responsibilities at the non-hospital site including "treating patients, training residents, and other administrative activities." CMS concludes that the predetermined compensation amount "implicitly also compensates the physician for supervising residents", which must be paid by the hospital.

Advocate: *Group practice business agreements vary greatly. In some, physicians do not received predetermined compensation; rather they share overhead expenses related to office space and management. Compensation is based on patient volume and, in effect, each physician is a solo practitioner.*

Calculating the Physician Supervisory Costs (pp 4823-25)

The proposed rule gives the option of using the current method of calculating supervisory costs or a method CMS defines as a "short cut". The "short cut" bases cost on a national average physician salary amount (authorized source) and a CMS determined "presumption" of the share of the teaching physician's time that he/she spends in direct GME activities. In the proposed rule, the presumption is 3 hours per week on GME activities regardless of the non-hospital site. The percentage of the physician's time would be determined by the dividing the 3 hours by the number of hours the non-hospital site is open.

Advocate: *We concur with the AAMC's recommendation that the Medical reasonable compensation equivalents (RCEs) should be used as the source for the national average physician salary data source.*

We are concerned that added to the August 2006 rule that states that hospitals cannot count didactic time in non hospital sites for DGME and IME payments, there is even less incentive for supervisory physicians to engage in non-billable activities in non hospital settings.

Resident Stipends and Benefits (pp 4825-26)

Costs are based on the FTE number of residents rotating to the site, not the total number of actual residents training at the site. In addition, the rule states that the hospital must use actual costs, which will "vary by specialty and program year."

Advocate: *Knowing the actual value of the resident's stipends and benefits becomes necessary under the proposed rule whereas we now need only know what the hospital incurred and need not know the actual amounts paid. It will increase our workload significantly. Residents at our hospitals rotate through a wide variety of locations, with many short stays- 35-45 different arrangements. Podiatry alone is at 13 different locations. More than 300 of our residents rotate to one or more of several non-hospital settings. Most of these experiences are not for a month, rather one-half day per week over a period of weeks. If we now are required to calculate time for each resident, each site, each period of time, the administrative paperwork load becomes extremely burdensome.*

Multiple Teaching Physicians and Residents (page 4825)

The issue of how the non hospital site cost formula would work in the case of multiple supervising physicians and multiple residents at a non hospital site is addressed by

applying a maximum of 1:1 resident-to-teaching physician ration "limit" in determining the total costs applicable to the non hospital site.

Advocate: *The ratios are an important issue because the supervisory cost issue comes into play when there is more than one physician at a site (remember that solo practitioners are viewed by CMS as not having supervisory costs.) Under a variety of circumstances, hospitals might need to incur less teaching physician costs to meet the 90 percent threshold.*

Teaching Hospitals With Resident Counts Greater Than Their Resident Caps

In a communication from AAMC, a conversation with CMS staff seems to indicate that if a hospital is over its cap, the hospital need not comply with the regulations if the non hospital site resident FTE count is equal to or less than the count by which the hospital is over cap.

> ***Advocate:*** *This is a significant issue, as many teaching hospitals are over cap. More information is needed on this matter and clarity regarding the inclusion or exclusion or these residents' counts related to cost reports.*

Contributors:

Steve Pyrcioch
Director, Reimbursement

Advocate Christ Medical Center
- Robert Stein, MD, Vice President, Medical Management
- Loreta Krutulis, Manager, Medical Education

Advocate Illinois Masonic Medical Center
- William Werner, MD, Vice President, Medical Management
- Rebecca Mammoser, Director, Medical Education

Advocate Lutheran General Hospital
- Kris Narishimhan, MD, Vice President, Medical Management
- Diane O'Gara, Manager, Medical Education

Submitter : Ms. Stephanie Wells **Date:** 03/23/2007

Organization : Louisisana Specialty Hospital

Category : Long-term Care

Issue Areas/Comments

LTC-DRG Classifications and Relative Weights

LTC-DRG Classifications and Relative Weights

See Attachment

CMS-1529-P-61-Attach-1.PDF

CMS-1529-P-61-Attach-2.PDF

#61

March 26, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850
Attention: CMS-1529-P, Mail Stop C4-26-5

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008
Proposed Annual Payment Rate Updates, and Policy Changes
File Code CMS-1529-P
Comments to Proposed Expansion of the 25 Percent Rule, Section V.B., 72 Fed. Reg. 4776, 4809 (Feb. 1, 2007)

Dear Administrator Norwalk

I am the Administrator/Chief Executive Officer for Louisiana Specialty Hospital, a long-term care hospital (LTCH) in the greater New Orleans area. I am writing to express my deep concern and comment over the Proposed Update to the Long-Term Acute Care Hospital Prospective Payment System Rule. As you know, LTCHs serve a critical role in the Medicare program. The proposed rule, if enacted, will be devastating to Medicare beneficiaries, particularly in the New Orleans area. Louisiana Specialty Hospital, in attempting to remain a viable going concern, will have no choice but to accept far fewer patients from its host hospital, West Jefferson Medical Center, and attempt to admit appropriate LTCH patients from other facilities outside of its New Orleans westbank locale. While Louisiana Specialty Hospital may or may not be successful and remain a going concern under this strategy, at best the result will be far fewer available acute care beds on the westbank, displaced patients forced to obtain long-term acute hospital care outside the westbank, significant discontinuity in patient care, and loss of patient freedom of choice.

PROPOSAL:

The proposed rule would extend the "25 Percent Rule" to all LTACHs, including those grandfathered by Congress from the hospital-within-a-hospital (HwH) requirements.

ISSUE:

Due to Hurricane Katrina, the New Orleans area is in a healthcare crisis. This crisis is well documented as there are currently 51% less hospital beds in the area. The number of beds per 1,000 residents is down by over a third. The wait times to be seen by emergency room personnel are greatly extended. It was documented that often these wait times are in excess of

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four to five hours, meaning that one could drive to another city for treatment faster than receiving care in our own community. Once seen by emergency room personnel, patients are often staying in the emergency rooms for days awaiting hospital bed availability. On occasion, patients can not even be transferred from the ambulance stretcher to an emergency room bed, holding up the first responders for hours. The short-term acute care hospitals are often on diversion for extended periods. There has been a significant reduction in nursing home beds and other discharge placement options are limited as well. In addition, local physicians continue to leave the New Orleans area and nurse staffing has been, and continues to be, an ongoing problem in this area. With the shortage of physicians, many residents are not seeking their regular treatments and are often in a dire healthcare situation once they attempt to receive treatment through the emergency room. Dr. Kevin Stephens, New Orleans' health director, explained to the Energy and Commerce Committee's Subcommittee on Health of the United States Congress that his analysis shows a 42% increase in the mortality rate in the city since the disaster, "strongly suggesting that our citizens are becoming sick and dying at a more accelerated rate than prior to Hurricane Katrina".

In addition, New Orleans is divided by the Mississippi River into what is called the "eastbank" and the "westbank". Generally, care is sought by residents in their immediate community and rarely do they cross the river to seek treatment. On the westbank, there are two short-term acute care hospitals: West Jefferson Medical Center and Ochsner Hospital's Westbank campus (previously Meadowcrest). West Jefferson Medical Center has an average daily census of 280 – 300, while Ochsner Westbank has an average daily census closer to 100. The facilities are included in CBSA 35380, which is quite large and includes Jefferson Parish, Orleans Parish, Plaquemine Parish, St. Bernard Parish, St. Charles Parish, St. John the Baptist Parish and St. Tammany Parish. West Jefferson Medical Center has its full service line available and treats the majority of medically complex patients on the westbank. It would be more likely that West Jefferson Medical Center would have a larger population of LTACH appropriate patients to move into the appropriate LTACH setting; however, due to the size of the CBSA, West Jefferson Medical Center does not demonstrate "dominance" in the CBSA.

Louisiana Specialty Hospital is an LTACH that shares a building with West Jefferson Medical Center. Congress grandfathered Louisiana Specialty Hospital from the HwH requirements, and accordingly, the facility has not been subject to the current 25 Percent Rule. We have provided a much needed service to long-term acute care patients in the community with practice patterns that have been established over many years (the facility opened in 1991). The facility remained open during Hurricane Katrina and has remained committed to the citizens of New Orleans.

As explained above, if the proposed rule is enacted, Louisiana Specialty Hospital, in attempting to remain a viable going concern, will have no choice but to accept far fewer patients from West Jefferson Medical Center, and attempt to admit appropriate LTCH patients from other facilities outside of the westbank. While Louisiana Specialty Hospital may or may not be successful and remain a going concern under this strategy, at best the result will be far fewer available acute care beds on the westbank, displaced patients forced to obtain long-term care hospital care outside the westbank, significant discontinuity in patient care, and loss of patient freedom of choice. The effect of this rule on West Jefferson Medical Center's Medicare

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March 20, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Ave. SW
Washington D.C. 20201

Dear Administrator Norwalk:

I am a Pulmonologist practicing in the New Orleans area and am writing to express concern and comment over the Proposed Update to the Long-Term Acute Care Hospital Prospective Payment System Rule. As you know, Long-Term Acute Care Hospitals (LTACHs) serve a critical role in the Medicare System and this rule contains proposals that are detrimental to the Medicare beneficiaries and physician care providers. Of primary concern to me is the provision to extend the "25 Percent Rule" to all LTACHs including those previously grandfathered under 42CFR412.22(f).

New Orleans is divided by the Mississippi River into what is called the "eastbank" and the "westbank". Since the devastation to the area with Hurricane Katrina, the New Orleans area has been and remains in a healthcare crisis. New Orleans has lost a significant number of physicians. My personal practice treats all pulmonary patients on the westbank. Prior to the storm, we had six pulmonologists, but now have only four treating the same area. I have lived in New Orleans for my entire life and it has been my experience, that care is sought by residents in their immediate community and rarely cross the river to seek treatment. On the westbank, there are two short-term acute care hospitals: West Jefferson Medical Center and Ochsner Hospital's Westbank campus (previously Meadowcrest). West Jefferson Medical Center has an average daily census of 280 – 300 while Ochsner Westbank has an average daily census closer to 100. I am currently working long days and would be unable to follow patients to yet another setting. Louisiana Specialty Hospital is the LTACH in West Jefferson Medical Center. The facility treats extremely complex patients and this proposed rule threatens to interrupt patient care or disrupt it by seeking to displace patients to other facilities in which other physicians must take over their care.

As I am sure you are aware, the healthcare crisis in New Orleans is well documented as there are currently 51% fewer hospital beds in the area. The number of beds per 1,000 residents is down by over a third. The impact on patients has been seen through extended wait times in the emergency room to receive treatment, possibly waiting days for a hospital bed to become available. This area is also experiencing an increase in the mortality rate. The decrease in available physicians and clinics has caused many residents not to seek routine treatment until in an emergent condition.

Recently, physicians set up and provided a free clinic for a short time. Residents stood in line for long periods just to receive basic medical care. I have traveled to a third world country to perform mission work and the similarities between this scene and my experience in Nicaragua was frightening and startling.

Louisiana Specialty Hospital has been grandfathered under 42CFR412.22(f) and thereby exempt from the current "25 Percent Rule" enacted for current HIH LTACHs. The facility has provided a much needed service to the long-term acute care patients in the community with practice patterns that have been established over many years (the facility opened in 1991). The facility remained open during Hurricane Katrina and has remained committed to the citizens of New Orleans.

As I mentioned, I live in New Orleans and have for my entire life. My brother is a physician and my father was a dentist with lifelong residencies in New Orleans. I am currently living in a gutted house so I continue to feel the effects of the storm in my personal life, and observe the effects on the lives of my patients, their families, and the entire New Orleans healthcare system. Because of the loss of pulmonologists in our practice, my partners and I are working very long days, and take frequent call. It would greatly impact care if our complex patients were to be transported to another facility. We literally would not have time in our day to travel to another facility. Because we four are the only pulmonolgists on the Westbank, thus caring for many of these critically ill patients, patients transferred to another facility would literally loose our care. Please understand that we are committed to our patients and our community, but the strain of this workload is becoming burdensome on us and our families.

The impact of this proposed rule on the New Orleans' area Medicare beneficiaries, physicians, and on Louisiana Specialty Hospital itself will be devastating and result in fewer short-term acute care beds available for treatment in a market with too few beds. It is imperative that CMS not enact regulations that will further deteriorate the healthcare system in the Greater New Orleans area. I am requesting that either:

1. The expansion of the "25 Percent Rule" be eliminated and that criteria be developed as a more appropriate alternative; or
2. If the expansion of the "25 Percent Rule" is enacted, that an exemption be granted to the area impacted by Hurricane Katrina, specifically to CBSA 35380, for a minimum period of five years, to allow for the rebuilding of the New Orleans healthcare system.

As a physician and a resident of the New Orleans area, I am asking for your help. Again, it is most imperative that we not enact regulations that will further deteriorate the healthcare system in the Greater New Orleans area.

Sincerely,

Elaine LaNasa MD

Elaine LaNasa, MD

Submitter : Dr. Gary Silko **Date:** 03/23/2007

Organization : Saint Vincent Family Medicine Residency Program

Category : Health Care Professional or Association

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

The proposals regarding paying "volunteer" preceptors continue to be confusing, difficult to implement and financially damaging to training of residents particularly in Family Medicine. This specialty has been and continues to be the one that places the most physicians in underserved areas both rural and inner city. It is also the training that utilizes the most non-hospital training sites and the most volunteer preceptors. When we began paying these volunteers they were stunned and most kept sending their checks back. They teach because of their devotion to passing on to the next generation of doctors what they were taught when they were interns and residents. They feel they are rewarded by being able to claim continuing medical education credit and knowing that many of these young men and women will care for some of the poorest segments of our society.

Many of the provisions already enacted have severely hurt our ability to maintain a strong training program. We are now being denied payments for such areas as practice management and research. Residents in family medicine are required to learn practice management by our accrediting bodies. Teaching residents how to run a practice efficiently and cost effectively is important in allowing them to be able to provide care to all patients regardless of their insurance status. Residents performing research in family medicine are looking at ways to improve the health of the communities in which they train - frequently with a focus on the poor and underserved.

The new "one day" rule has forced us to eliminate many of our lectures to our residents further comprimising their training.

Finally despite the attempts to "clarify" the situation for fiscal intermediaries we continue to see them "interpret" these rules as they see it and not as CMS sees it. Many programs have been forced to "give back" hundreds of thousands of dollars based on arbitrary at best decisions by these intermediaries. While this rule is an attempt at clarifying the situation we believe there is still much leeway for some fiscal intermediaries to continue to interpret the rules their own ways.

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

Paying "volunteer" preceptors has had a serious negative financial impact on our program as well as the majority of training programs in family medicine. Being denied GME and IME moneys for residents learning practice management, doing researeh and attending lectures has hurt us even further. The ultimate impact will be the continued closure or downsizing of family medicine programs. Many of those programs (including ours) are the main source of care for patients who are uninsured or underinsured in the communities the residencies are located. In addition with the decrease in numbers of family medicine residency trained physicians there will be less physicians to practice in the rural and inner city areas . These patients are already having difficulty accessing quality medical care. These proposals will make this aeeess even more difficult.

Submitter : **Date: 03/23/2007**

Organization : **Noland Health Services**

Category : **Long-term Care**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1529-P-63-Attach-1.PDF

Long Term Hospital of Dothan

#63

March 23, 2007

BY ELECTRONIC FILING

Hon. Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1529-P
Mail Stop C4-26-5
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: ***Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes; Proposed Rule, 72 Fed. Reg. 4776 (February 1, 2007)***

Dear Ms. Norwalk:

This letter presents comments and recommendations of Noland Health Services, ("NHS") to certain aspects of the proposed annual payment rate updates and policy changes under the prospective payment system for long-term acute care hospitals ("LTACH PPS") for rate year ("RY") 2008, which were published by the Centers for Medicare & Medicaid Services ("CMS") on February 1, 2007.

NHS is a not-for-profit health care system headquartered in Birmingham, AL, that operates five (5) LTCH Hospital-in-a-Hospital ("HIH") hospitals located in Montgomery, Birmingham, Dothan, Anniston and Tuscaloosa, AL. NHS is a member of ALTHA, The Acute Long Term Association, and supports the comments made by ALTHA in their letter of March 23.

NHS is also the preeminent LTCH provider in the state of Alabama, with 71% of the state's LTCH hospitals. We have been providing LTCH care for almost 10 years, as part of our 94 year old not-for-profit mission. We are gravely concerned that the future of this mission is jeopardized by CMS' continued focus on arbitrary and capricious reimbursement changes, rather than addressing a rationalization of the need for this very special level of care for the small segment of Medicare beneficiaries who require extended acute care.

My local LTACH is located in Dothan, AL. We are celebrating our third year of operation on Monday, March 23, 2007. The facility has served 642 patients during this time. We have experienced very good patient outcomes, which includes a fifteen (15%) mortality rate, well below the national average of twenty-five (25%). Many of the very complex patient diagnoses admitted to the LTACH had to be managed out-of-state prior to the opening of our facility. The facility has met the healthcare needs of patients, families, and our community. These complex patients need the ability and the option of patient access to the types of service needed for improvement, recovery, and the increase in quality of life.

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NHS opposes the arbitrary and inappropriate reductions in long-term care hospital ("LTACH") payments that will result if these proposed changes to the LTACH PPS are implemented. NHS has reviewed the proposed rule and agrees with ALTHA that it suffers from a number of recurring problems. First, as with other recent rulemakings affecting LTACHs, CMS continues to rely upon materially flawed and incomplete data in developing their proposed changes to LTACH payments for RY 2008. Second, NHS does not believe that CMS has seriously considered the legal and equitable issues which this proposed rule raises with regard to patient freedom of choice, physician medical decision-making, and the disparate impact on LTACHs in underserved areas.

NHS recommends that CMS reconsider its proposed changes to the LTACH PPS in light of the Medicare Payment Advisory Commission ("MedPAC") recommendations in June 2004 that the certification criteria for the Medicare LTACH provider category be strengthened to ensure that LTACH payments are being made to only those providers that are administering medically complex care to severely ill patients. NHS supports this approach as a more defined method for limiting LTACH payments to hospitals that are truly caring for a medically complex patient population. Unfortunately, the proposals that CMS advances in this proposed rule continue to rely on arbitrary and unproven payment reductions to achieve policy goals that are, in many cases, compatible with more comprehensive LTACH certification criteria but will not achieve those goals and will significantly hinder the ability of our LTCH's to continue to provide quality patient care to Medicare beneficiaries.

Noland Health Services strongly believes that arbitrary payment reductions are the wrong approach if quality of care is to be encouraged.

First and foremost, CMS should reconsider its proposed policy for extending the so-called "25% rule" from hospitals-within-hospitals ("HIH's") to all LTACH's, and its proposed policy to enlarge the category of short-stay outlier ("SSO") cases. To the extent that CMS is concerned about "inappropriate" admissions to LTACH's, it should implement more appropriate non-payment approaches such as pre-admission physician certifications, uniform admission screening criteria, and more extensive Quality Improvement Organization ("QIO") reviews. 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, NHS supports that goal. 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. Moreover, the cumulative effect of these policies will result in significantly reduced and even negative operating margins in our not-for-profit LTACH's. Establishing payment policies that reimburse Medicare providers below the cost of care violates a basic premise of the Medicare program.

The proposed rule takes the next step in a series of apparently calculated efforts by CMS to reverse the growth in the number of LTACH's and reduce reimbursement to LTACH's for caring for Medicare beneficiaries suffering from complex medical conditions that require long hospital stays. In continuing to reduce payment rates and expose additional LTACH cases to payment rates for short-term acute care hospitals ("STACH's"), CMS fails to account for prior adjustments to the LTACH PPS in the past few years that have had a great deal to due with the lack of growth of new LTACH's in Alabama. CMS's own data shows that growth in the number of LTACH's has stopped. According to the December 2006 CMS Provider of Service file, there was a net reduction of one LTACH in 2006. With regard to margins, MedPAC estimated LTACH margins to be at or near zero even before the proposed rule was released. A comprehensive analysis of the proposed rule reveals that LTACH margins will be between negative 3.7% and negative 5.7% if the proposed policies are finalized. This reduction in payment significantly below the cost of providing care will dramatically impact the ability of all LTCH's, as well as NHS's, to provide quality services to Medicare beneficiaries. CMS should not engage in this type of punitive rulemaking when Congress has provided express statutory authority for LTACH's and a PPS that reasonably reimburses LTACH's for the cost of care.

In the preamble to the proposed rule, CMS offers one primary justification in support of its two most significant policy proposals to extend the so-called "25% rule" from HIH's to all LTACH's and to enlarge the category of SSO cases: its belief that LTACH's are acting like units of STACH's, such that it believes that patients admitted to LTACH's are continuing the same episode of care that began during the patient's stay in the referring STACH. However, CMS fails to provide credible evidence that these interrelated issues are, in fact, occurring. CMS's own independent consultant, RTI International, has stated that the issue of LTACH's offering a continuation of a single episode of care is "poorly understood." The *opposite* is true – STACH's are not discharging patients to our LTACH's "early" and Medicare is *not* paying twice for a single episode of care. CMS's own data shows that LTACH patients have different characteristics than are evident during their preceding stay in a STACH. The data also shows that LTACH patients receive different treatments to address different clinical needs following a stay in a STACH. Furthermore, differences in the medical complexity and average length of stay of LTACH cases substantiate reimbursement at the LTACH PPS rate, not the inpatient PPS rate for STACH's. CMS also has not presented evidence that LTACH's are acting like units of general acute care hospitals. The existence of primary referral and discharge relationships between our LTACH's and STACH's are both required by law and necessary to facilitate quality patient care in the most appropriate patient care setting.

NHS has serious concerns about a number of unintended consequences associated with CMS's proposal to expand the 25% rule to freestanding LTACH's and grandfathered LTACH HIH's and satellite facilities. CMS is proposing to expand the existing payment limitation threshold to any LTACH or satellite of an LTACH that discharges during a single cost reporting period more than 25% (or applicable percentage for rural, single-urban, or MSA-dominant hospitals) of Medicare patients admitted from any non-co-located individual hospital. The original 25% rule was adopted by CMS in regulations that were recently published on August 11, 2004 and have yet to be fully implemented. Until the existing 25% rule is fully implemented, it is impossible to know the full impact of the existing rule on LTACH's and the impact that rule is having on patient access and quality of care for Medicare beneficiaries. What we do know is that the existing 25% rule, in combination with CMS's other payment policies has reduced growth in the net number of new LTACH's to negative numbers. Yet CMS is advancing a policy that, without question, will further restrict patient choice and diminish access to quality care by imposing a rigid, arbitrary, and extremely limiting quota on the number patients who will be fairly reimbursed at the LTACH PPS rates.

Further, limitations on the number of patients admitted from a single hospital severely undermine physician judgment to determine what clinical setting is in the best interest of the patient. Through its other policies, CMS has repeatedly reinforced a patient's right to choose a health care provider. But this proposed policy will have a discriminatory impact on LTACH's and Medicare beneficiaries. For no clinical reason, patients in the 26th percentile and higher will be paid like general acute care patients when their complex medical needs and relatively long stays require LTACH care. The LTACH's that we operate that are located in underserved areas or communities with less than four general acute care hospitals where LTACH's lack the ability to offset reduced patient referrals from one hospital with a greater number of LTACH-level patients from other hospitals will be extremely negatively impacted by this rule. These results have nothing to do with the care required by a particular patient or the quality of care offered by a particular LTACH, and has everything to do with the unintended consequences that will result from the arbitrary nature of establishing a payment limitation that has no relevance to patient or facility level criteria. For these reasons, the proposed rule not only penalizes us and other LTACH providers, it penalizes all Medicare beneficiaries.

NHS is concerned that CMS has set forth yet another proposal to expand the class of SSOs that would effectively be paid at STACH rates without understanding the types of patients that would be treated as SSOs under the proposed policy. In the proposed rule, CMS indicates that it is considering lowering LTACH payment to the IPPS rate for cases with a length of stay that is less than the average

length of stay plus one standard deviation for the same DRG under IPPS. Cases with a covered length of stay less than or equal to one standard deviation for the same DRG under IPPS would be paid at an amount comparable to the IPPS per diem.

As noted above, CMS offers the same justification for this short stay policy as is offered for the 25% rule policy. CMS believes that LTACH patients with "very short" lengths of stay have not completed their "episode of care" and should not have left the STACH. CMS's own data provides no support for this "belief." Moreover, rather than capture truly short-stay patients with lengths of stay that approximate STACH patient lengths of stay, as suggested, this policy would actually have the perverse effect of treating as SSOs many LTACH patients with lengths of stay that approach the 25-day average for LTACH certification (*e.g.*, 21 days, 23 days). NHS strongly encourages CMS not to make further changes in the SSO policy based upon the data provided herein and because MedPAR data is not available yet to evaluate whether the SSO policy changes put into effect last year are achieving the desired policy goals. CMS has produced no study or analysis in the proposed rule showing that inappropriate admissions constitute a material portion of SSO cases. To the contrary, the opposite is true: SSO cases are, in fact, appropriate for admission to LTACH's for a number of reasons, including the fact that even shorter stay LTACH's patients are more severely ill than comparable STACH patients; difficulty in screening SSOs from admission to LTACH's based upon clinical criteria at the time of discharge from the referring hospital; the inability of clinicians to predict when LTACH patients will expire; and the inherent averaging of patient lengths of stay that is the foundation of the current LTACH certification criteria and PPS. If the patient meets InterQual admission criteria, and can be reasonable expected to stay for an extended period of time, and a physician admits the patient, the LTCH should not be so severely financially penalized that negative operating margins are created. 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. It would seem that CMS would be aware that the rate of payment for these cases will be insufficient to cover NHS's and other LTCH's reasonable and necessary costs in providing care to this segment of LTACH patients.

The proposed policies violate the statutory requirement that CMS reimburse LTACH's on a per discharge basis that reflects the reasonable and necessary cost of providing services in a hospital having an *average* length of stay of greater than 25 days. The proposed policies will continue to erode the LTACH PPS by reimbursing LTACH's for fewer and fewer medically complex patients at the LTACH PPS rates. The LTACH PPS must adequately reimburse LTACH's for the costs they incur in caring for Medicare beneficiaries. The cumulative effect of the proposed changes to the LTACH PPS will be to bring LTACH reimbursement below the cost of care. This level of reimbursement is unsustainable and will inevitably result in a decrease in access to LTACH services in spite of the increasing number of Medicare beneficiaries and the overall aging of the country's population. The Congress, the LTACH industry, MedPAC, and RTI International all agree that LTACH's serve an important role in caring for medically complex patients who need long-term hospital stays. CMS should develop policies that reflect this consensus. We encourage CMS to work with the Congress to develop meaningful facility and patient certification criteria for LTACH's, as proposed in H.R. 562 and S. 338.

NHS objects to CMS's proposal to provide less than the full market basket update of 3.2% for RY 2008. An increase of less than the market basket will not account for the cost of goods and services required to deliver LTACH services and will result in rates below the cost of care. The full market basket update is an accurate reflection of items and services purchased to treat Medicare beneficiaries and is necessary to account for the rising cost of inputs. The federal rate must be updated in accordance with the market basket to keep LTACH payment rates in step with the higher cost of price inputs.

In summary, NHS urges CMS to carefully consider the comments and data provided in this letter and to reexamine the policies advanced in the proposed rule. The types of patients admitted to LTACH's, the care provided during an LTACH stay, and the relationships that LTACH's have with

STACH's show that Medicare is not paying twice for a single episode of care. LTACH's serve a distinct and important purpose in the health care continuum. Noland's LTCH's are vital to the mission of NHS, of meeting unmet healthcare needs for an underserved population in Alabama. CMS's payment policies should reflect this in a manner that fairly compensates LTACH's for the care they provide to thousands of Medicare beneficiaries in Alabama and across the nation.

Sincerely,

Kaye Burk

Kaye Burk, Administrator
Long Term Hospital of Dothan

Submitter : **Date: 03/23/2007**

Organization :

Category : **Hospital**

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

See Attachment

CMS-1529-P-64-Attach-1.DOC

#64

March 23, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1529-P
P.O. Box 8015
Baltimore, Maryland 21244-8015

Re: Comments on Medicare Program; 2008 Proposed Update Rule
Published at 72 Federal Register 4776 *et seq.*

Dear Ms. Norwalk:

Madonna Rehabilitation Hospital submits these comments on proposed rules published on February 1, 2007 at 72 *Fed. Reg.* 4776 et seq. This rulemaking seeks to make significant changes to the admission practices of long-term care hospitals (LTCHs) as well as payment policies.

Madonna Rehabilitation Hospital is a not-for-profit Catholic facility located in Lincoln, Nebraska and is sponsored by Diocesan Health Ministries, a division of the Catholic Dioceses of Lincoln. Originally founded in 1958 as an 111-bed facility by Benedictine Sisters whose mission was to "take care of the sick as Christ", the hospital has since grown to 303 beds on a 24 acre campus dedicated to the provision of rehabilitation care. Madonna is considered a local, regional and national provider of comprehensive post-acute care services including LTCH.

Madonna serves a significant percentage of Medicare patients residing in the Lincoln area, and is very concerned with CMS' proposed expansion of the 25% rule to freestanding and grandfathered hospitals and its "consideration" of a policy to expand the short stay outlier ("SSO") payment policy to allow "extremely" SSO cases to be paid comparable to IPPS cases. Madonna was surprised to find little corresponding data to support the changes outlined in the proposed rule, and the absence of action that would begin to implement previous MedPAC recommendations surrounding patient admission criteria. The two proposals would reduce payments to Madonna Rehabilitation Hospital in fiscal year 2008, forcing Madonna to operate at a loss when treating Medicare patients. Madonna urges CMS to not adopt the proposed expansion of the 25% rule and to reject its consideration of the extremely SSO policy because the continued operation of Madonna and the patients it serves will be placed in jeopardy if they are adopted.

In the preamble to the update rule, CMS repeatedly justifies both of its proposals by making statements that Madonna perceives to be incorrect and unsupported. Specifically, there is no supporting data to indicate that the LTCH is behaving like a ACH, or that the LTCH is acting like a step-down unit for a ACH, or that the patient presumably was discharged by the ACH to the LTCH during the same episode of care and the LTCH is not providing complete treatment. CMS points to the statutory difference between LTCHs and ACHs that was intended to pay LTCHs based upon "the different resource use" of LTCHs as compared to ACHs. In fact, LTCHs <u>do</u> provide different services to patients, and patients in LTCHs <u>do</u> utilize different resources than ACHs, making it inappropriate to pay LTCH discharges under the IPPS. CMS' own contractor, RTI, noted in the Executive

Summary to its report that "[u]nderstanding whether LTCH hospitals are substituting for services already paid to IPPS hospitals or whether LTCHs are providing specialized services is not well understood." 72 Fed. Reg. 4885.

As described in greater detail in the comments submitted by NALTH, physicians at ACHs use their expertise and experience to discharge certain patients to LTCHs because the specialized care they can receive at the LTCH is very different than the services provided at an ACH, and such care, and the timing of such care, clearly are in the best interests of the patient's medical care. In general, ACHs are "diagnosis focused" and provide critical care to acutely ill patients by focusing on a single clinical dimension, whereas the LTCH is designed to provide the complete array of team-based services that can focus on the recovery of the whole patient. LTCHs often help patients recover all functions (both cognitive and physical) and return to their community and participate in their life roles. ACHs simply are not designed to provide these services, and there is no current incentive for them to expend the significant resources to try to replicate those specialized services that already exist in LTCHs. The physicians at the ACH also make the medical determination of when the patient is appropriate to be transferred from the ACH to a LTCH based upon the patient's condition, medical needs, and availability of appropriate services. It makes little sense for a patient to remain at an ACH instead of being transferred to a LTCH, and thus delay (or eliminate entirely) the commencement of needed specialty services, purely for payment system reasons.

The Lewin Group was commissioned by the National Association of Long Term Hospitals (NALTH) to review and critically appraise the LTCH RY 2008 Prospective Payment System Notice of Proposed Rulemaking. Lewin has demonstrated based upon their analysis that SSO patients in a LTCH cost far more than patients with the same DRG in an ACH, and their length of stay in a LTCH more than double of those with the same DRG in an ACH. There simply is no support for CMS' belief or presumption that patients in LTCHs should be paid like patients in an ACH.

Expanded 25% rule

CMS justifies expansion of the 25% rule to all LTCHs, including grandfathered co-located LTCHs and freestanding LTCHs, based on the presumption that the ACH's discharge to the LTCH presumably is a "premature discharge" if the patient has not reached cost outlier status at the ACH. As noted above, there is no clinical or financial evidence to support CMS' conclusion that the patient is discharged prematurely. RTI, CMS' own contractor investigating these issues, has concluded that it cannot state that LTCHs are substituting for services already paid to IPPS hospitals. Without such evidence the proposal should be withdrawn. In fact, there is significant clinical and financial support presented by NALTH that ACH patients are discharged based upon the expertise of the ACH physician, who has determined that it is appropriate for the patient to receive the specialized services of the LTCH at that time in order to maximize the patient's recovery.

Madonna Rehabilitation Hospital questions the basis of the 25% threshold itself. CMS has presented no evidence to show that there is any statistical basis for applying such an arbitrary number throughout the country to penalize LTCHs.

Expanding the 25% rule to all LTCHs not only will jeopardize patients' access to appropriate medical care, but the significant and inappropriate financial losses it will generate will all but guarantee the closure of a significant number of LTCHs, thereby preventing access to these unique services by many Medicare beneficiaries.

The proposal to expand the 25% rule to grandfathered hospitals, such as Madonna Rehabilitation Hospital, violates the statutory protection given by Congress in recognition of this unique status.

The proposal to expand the 25% rule fails to recognize the many localities in which LTCHs serve a small number of independent ACHs, thereby making it impossible for them to satisfy the 25% rule despite no control or

ability to direct or influence the admission patterns. Madonna serves all three of the independent ACHs in Lincoln, two of which meet the definition of an MSA dominant hospital. The proposed rule is unclear in a number of areas surrounding the calculation of the admission thresholds and payment methodologies for MSA dominant hospitals. It appears, for example, that there could be situations where the threshold would be less than the 25% threshold if the percentage of admissions from that hospital was less than 25% in the FY 2005 cost reporting period. The proposed rule is silent regarding how the percentage thresholds may change in the future to allow for MSA hospital growth and subsequent increased LTCH admissions. The proposed rule also does not discuss threshold percentage calculations for new MSA dominant hospitals entering the market or for mergers or acquisitions that impact the MSA dominant status of an ACH.

Madonna has other 25 % rule administrative and billing concerns/questions as follows:

- How will the fiscal intermediary (FI) of the LTCH monitor high cost outlier (HCO) status from MSA dominant hospitals with another FI until the MACs have been set?
- How will claims be adjusted for possible late charges and credits in regards to HCO status?
- What is the projected payment error rate for the proposed rule?
- Will LTCH providers have access to common working file information from the referring providers to determine if HCO has been met?

Madonna is very concerned that the rule is administratively unfeasible, unworkable from a hospital's perspective, cumbersome or perhaps not feasible for the Medicare program to administer and, most importantly, will operate to delay or deny patient access to care.

Extreme SSO policy

As noted above, the extreme SSO policy CMS is considering is contrary to clinical and financial realities. Under the current SSO policy a LTCH will at best receive only its cost for a SSO; there is no incentive for a LTCH to admit a patient who is likely to become a SSO. Under the extreme SSO policy being considered a LTCH would undoubtedly lose a significant sum on treating the patient.

Besides not having any financial incentive to admit an extreme SSO, CMS also assumes that LTCHs are able to predict, prior to admission, which patients will become SSOs, much less extreme 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. 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.

The following case exemplifies the difficulties that LTCHs face on a regular basis in not being able to predict which patients will become SSO cases in spite of appropriate prescreening. Madonna recently admitted a patient following open heart surgery for care and close monitoring of his medical condition as their was a history of chronic obstructive pulmonary disease and congestive heart failure. The pre-admission assessment showed that the patient was a good candidate based on his physical functioning and medical needs. Shortly after he admitted, his

medical status changed and the patient developed nausea and vomiting due to an ileus and acute renal failure due to hypotension. His condition then improved due to aggressive medical management. On day three of the patient's LTCH stay, his condition suddenly deteriorated and he had a respiratory and cardiac arrest. The patient was discharged back to acute care where he expired. This course of events was certainly not anticipated when the patient was initially admitted to Madonna. Under the extreme SSO policy being considered, Madonna would undoubtedly have lost a significant sum on treating the above patient who required complex medical care including treatment such as IV Dopamine at a fixed dose and other IV medications through a PICC line, TPN, respiratory treatments etc.

In addition, there is no basis for a proposed rule which assumes that SSO cases should have remained in acute hospitals. Some SSO cases are not admitted from acute hospitals, but rather are admitted from home or another level of post-acute care at the direction of a patient's attending physician. It is inappropriate for CMS to presume that a patient admitted to a LTCH from a non-acute hospital setting, at the direction of the patient's attending physician, who subsequently becomes a SSO should not have been admitted to the LTCH in the first place.

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

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

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

Recommendations:

Madonna recommends that a standstill be put in place on the 25% rule, which currently provides a payment penalty based on the percentage of patients admitted from a co-located hospital to a LTCH. Furthermore, no payment penalty based on admission source would be applied to freestanding or grandfathered LTCHs.

Madonna recommends and fully supports the MedPAC recommendations made in March of 2004 to develop and implement patient and facility criteria to assure appropriate placement of patients in LTCHs. There should be standardized LTCH admission, continued stay and discharge criteria for all LTCHs across the country. Madonna would support a time limit for the Secretary to implement the new LTCH facility and patient criteria.

Madonna recommends that CMS increase its review of the medical necessity of Medicare beneficiary admissions to LTCHs and initiate review of the medical necessity of continued patient stays. This would start to address concerns raised by MedPAC as to the appropriate placement of patients in LTCH.

Finally, Madonna would support legislation for a moratorium on new LTCHs to address CMS concerns regarding increases in the number of LTCHs. The moratorium should be time limited with the Secretary being required to submit a report to Congress on the results of the three-year post-acute care payment reform demonstration program required by Section 5008 of the Deficit Reduction Act of 2005.

The above recommendations would re-align CMS' policies to a patient-centered approach versus imposing payment reductions as a mechanism to regulate patient access to LTCHs, and would result in new Medicare program savings.

In view of the foregoing, Madonna Rehabilitation Hospital respectfully requests that CMS not expand the 25% rule to freestanding and grandfathered hospitals, and that it reject the extreme SSO policy under consideration. We suggest that CMS work with NALTH and other interested parties on a more effective clinical means to define patients most appropriate for long-term acute hospital care.

Sincerely,

Susan Klanecky, RN, BSN, CCM, CRRN
Director, Admissions and Case Management

Paul A Dongilli, Jr., Ph.D., FACHE
Executive Vice President and Chief Operations Officer

Submitter : Mrs. Susan Klanecky **Date:** 03/23/2007

Organization : Madonna Rehabilitation Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1529-P-65-Attach-1.DOC

#65

March 23, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1529-P
P.O. Box 8015
Baltimore, Maryland 21244-8015

Re: Comments on Medicare Program; 2008 Proposed Update Rule
Published at 72 Federal Register 4776 *et seq.*

Dear Ms. Norwalk:

Madonna Rehabilitation Hospital submits these comments on proposed rules published on February 1, 2007 at 72 *Fed. Reg.* 4776 et seq. This rulemaking seeks to make significant changes to the admission practices of long-term care hospitals (LTCHs) as well as payment policies.

Madonna Rehabilitation Hospital is a not-for-profit Catholic facility located in Lincoln, Nebraska and is sponsored by Diocesan Health Ministries, a division of the Catholic Dioceses of Lincoln. Originally founded in 1958 as an 111-bed facility by Benedictine Sisters whose mission was to "take care of the sick as Christ", the hospital has since grown to 303 beds on a 24 acre campus dedicated to the provision of rehabilitation care. Madonna is considered a local, regional and national provider of comprehensive post-acute care services including LTCH.

Madonna serves a significant percentage of Medicare patients residing in the Lincoln area, and is very concerned with CMS' proposed expansion of the 25% rule to freestanding and grandfathered hospitals and its "consideration" of a policy to expand the short stay outlier ("SSO") payment policy to allow "extremely" SSO cases to be paid comparable to IPPS cases. Madonna was surprised to find little corresponding data to support the changes outlined in the proposed rule, and the absence of action that would begin to implement previous MedPAC recommendations surrounding patient admission criteria. The two proposals would reduce payments to Madonna Rehabilitation Hospital in fiscal year 2008, forcing Madonna to operate at a loss when treating Medicare patients. Madonna urges CMS to not adopt the proposed expansion of the 25% rule and to reject its consideration of the extremely SSO policy because the continued operation of Madonna and the patients it serves will be placed in jeopardy if they are adopted.

In the preamble to the update rule, CMS repeatedly justifies both of its proposals by making statements that Madonna perceives to be incorrect and unsupported. Specifically, there is no supporting data to indicate that the LTCH is behaving like a ACH, or that the LTCH is acting like a step-down unit for a ACH, or that the patient presumably was discharged by the ACH to the LTCH during the same episode of care and the LTCH is not providing complete treatment. CMS points to the statutory difference between LTCHs and ACHs that was intended to pay LTCHs based upon "the different resource use" of LTCHs as compared to ACHs. In fact, LTCHs <u>do</u> provide different services to patients, and patients in LTCHs <u>do</u> utilize different resources than ACHs, making it inappropriate to pay LTCH discharges under the IPPS. CMS' own contractor, RTI, noted in the Executive

Summary to its report that "[u]nderstanding whether LTCH hospitals are substituting for services already paid to IPPS hospitals or whether LTCHs are providing specialized services is not well understood." 72 Fed. Reg. 4885.

As described in greater detail in the comments submitted by NALTH, physicians at ACHs use their expertise and experience to discharge certain patients to LTCHs because the specialized care they can receive at the LTCH is very different than the services provided at an ACH, and such care, and the timing of such care, clearly are in the best interests of the patient's medical care. In general, ACHs are "diagnosis focused" and provide critical care to acutely ill patients by focusing on a single clinical dimension, whereas the LTCH is designed to provide the complete array of team-based services that can focus on the recovery of the whole patient. LTCHs often help patients recover all functions (both cognitive and physical) and return to their community and participate in their life roles. ACHs simply are not designed to provide these services, and there is no current incentive for them to expend the significant resources to try to replicate those specialized services that already exist in LTCHs. The physicians at the ACH also make the medical determination of when the patient is appropriate to be transferred from the ACH to a LTCH based upon the patient's condition, medical needs, and availability of appropriate services. It makes little sense for a patient to remain at an ACH instead of being transferred to a LTCH, and thus delay (or eliminate entirely) the commencement of needed specialty services, purely for payment system reasons.

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- Will LTCH providers have access to common working file information from the referring providers to determine if HCO has been met?

Madonna is very concerned that the rule is administratively unfeasible, unworkable from a hospital's perspective, cumbersome or perhaps not feasible for the Medicare program to administer and, most importantly, will operate to delay or deny patient access to care.

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In addition, there is no basis for a proposed rule which assumes that SSO cases should have remained in acute hospitals. Some SSO cases are not admitted from acute hospitals, but rather are admitted from home or another level of post-acute care at the direction of a patient's attending physician. It is inappropriate for CMS to presume that a patient admitted to a LTCH from a non-acute hospital setting, at the direction of the patient's attending physician, who subsequently becomes a SSO should not have been admitted to the LTCH in the first place.

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

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

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

Recommendations:

Madonna recommends that a standstill be put in place on the 25% rule, which currently provides a payment penalty based on the percentage of patients admitted from a co-located hospital to a LTCH. Furthermore, no payment penalty based on admission source would be applied to freestanding or grandfathered LTCHs.

Madonna recommends and fully supports the MedPAC recommendations made in March of 2004 to develop and implement patient and facility criteria to assure appropriate placement of patients in LTCHs. There should be standardized LTCH admission, continued stay and discharge criteria for all LTCHs across the country. Madonna would support a time limit for the Secretary to implement the new LTCH facility and patient criteria.

Madonna recommends that CMS increase its review of the medical necessity of Medicare beneficiary admissions to LTCHs and initiate review of the medical necessity of continued patient stays. This would start to address concerns raised by MedPAC as to the appropriate placement of patients in LTCH.

Finally, Madonna would support legislation for a moratorium on new LTCHs to address CMS concerns regarding increases in the number of LTCHs. The moratorium should be time limited with the Secretary being required to submit a report to Congress on the results of the three-year post-acute care payment reform demonstration program required by Section 5008 of the Deficit Reduction Act of 2005.

The above recommendations would re-align CMS' policies to a patient-centered approach versus imposing payment reductions as a mechanism to regulate patient access to LTCHs, and would result in new Medicare program savings.

In view of the foregoing, Madonna Rehabilitation Hospital respectfully requests that CMS not expand the 25% rule to freestanding and grandfathered hospitals, and that it reject the extreme SSO policy under consideration. We suggest that CMS work with NALTH and other interested parties on a more effective clinical means to define patients most appropriate for long-term acute hospital care.

Sincerely,

Susan Klanecky, RN, BSN, CCM, CRRN
Director, Admissions and Case Management

Paul A Dongilli, Jr., Ph.D., FACHE
Executive Vice President and Chief Operations Officer

Submitter : **Mr. Michael Batchelor** **Date: 03/23/2007**

Organization : **North Greenville Hospital**

Category : **Long-term Care**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-1529-P-66-Attach-1.DOC

#66

North Greenville Hospital
Long Term Acute Care
807 N. Main Street (HWY. 276)
Travelers Rest, SC 29690-1551

March 23, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1529-P
P.O. Box 8015
Baltimore, Maryland 21244-8015

Re: Comments on Medicare Program; 2008 Proposed Update Rule Published at 72 Federal Register 4776 *et seq.*

Dear Ms. Norwalk:

North Greenville Hospital submits these comments on proposed rules published on February 1, 2007 at 72 *Fed. Reg.* 4776 et seq. This rulemaking seeks to make significant changes to the admission practices of long-term care hospitals (LTCHs) as well as payment policies.

North Greenville Hospital was established on August 29, 2003 and is located at 807 North Main Street Travelers Rest, SC 29690. It serves a significant percentage of Medicare patients residing in the Upstate of South Carolina. CMS' proposed expansion of the 25% rule to freestanding and grandfathered hospitals, and its "consideration" of a policy to expand the short stay outlier ("SSO") payment policy to allow "extremely" SSO cases to be paid comparable to IPPS cases, both are unfair and unsupported by facts, and contrary to the clinical and financial data available. The two proposals would drastically reduce payments to North Greenville Hospital in fiscal year 2008 by approximately 25 percent, forcing North Greenville Hospital to operate at a loss when treating Medicare patients. North Greenville Hospital urges CMS to not adopt the proposed expansion of the 25% rule and to reject its consideration of the extremely SSO policy because the continued operation of North Greenville Hospital and the patients it serves will be placed in jeopardy if they are adopted.

In the preamble to the update rule CMS repeatedly justifies both of its proposals by making the generalized, unsupported, and incorrect statements that in the situations the proposals are intended to address the LTCH is behaving like a ACH, or that the LTCH is acting like a step-down unit for a ACH, or that the patient presumably was discharged by the ACH to the LTCH during the same episode of care and the LTCH is not providing complete treatment. CMS points to the statutory difference between LTCHs and ACHs that was intended to pay LTCHs based upon "the different resource use" of LTCHs as compared to ACHs. In fact, LTCHs do provide different services to patients, and patients in LTCHS they do utilize different resources than ACHs, making it

inappropriate to pay LTCH discharges under the IPPS, and CMS has presented no data to the contrary to support its proposals other than presumptions and beliefs. CMS' own contractor, RTI, noted in the Executive Summary to its report that "[u]nderstanding whether LTCH hospitals are substituting for services already paid to IPPS hospitals or whether LTCHs are providing specialized services is not well understood." 72 Fed. Reg. 4885.

As described in greater detail in the comments submitted by NALTH, physicians at ACHs use their expertise and experience to discharge certain patients to LTCHs because the specialized care they can receive at the LTCH is very different than the services provided at an ACH, and such care, and the timing of such care, clearly are in the best interests of the patient's medical care. In general, ACHs are "diagnosis focused" and provide critical care to acutely ill patients by focusing on a single clinical dimension, whereas the LTCH is designed to provide the complete array of team-based services that can focus on the recovery of the whole patient. LTCHs often help patients recover all functions (both cognitive and physical) and return to the community. ACHs simply are not designed to provide these services, and there is no current incentive for them to expend the significant resources to try to replicate those specialized services that already exist in LTCHs. The physicians at the ACH also make the medical determination of when the patient is appropriate to be transferred from the ACH to a LTCH based upon the patient's condition, medical needs, and availability of appropriate services. It makes little sense for a patient to remain at an ACH instead of being transferred to a LTCH, and thus delay (or eliminate entirely) the commencement of needed specialty services, purely for payment system reasons.

Despite CMS's generalized statements to the contrary, Lewin has demonstrated that SSO patients in a LTCH cost far more than patients with the same DRG in an ACH, and their length of stay in a LTCH more than double of those with the same DRG in an ACH. There simply is no support for CMS' belief or presumption that patients in LTCHs should be paid like patients in an ACH.

Expanded 25% rule

CMS justifies expansion of the 25% rule to all LTCHs, including grandfathered co-located LTCHs and freestanding LTCHs, based on the presumption that the ACH's discharge to the LTCH presumably is a "premature discharge" if the patient has not reached cost outlier status at the ACH. As noted above, there is no clinical or financial evidence to support CMS' conclusion that the patient is discharged prematurely. RTI, CMS' own contractor investigating these issues, has concluded that it cannot state that LTCHs are substituting for services already paid to IPPS hospitals. Without such evidence the proposal should be withdrawn. In fact, there is significant clinical and financial support presented by NALTH that ACH patients are discharged based upon the expertise of the ACH physician, who has determined that it is appropriate for the patient to receive the specialized services of the LTCH at that time in order to maximize the patient's recovery.

The proposal to expand the 25% rule fails to recognize the many localities in which LTCHs serve a small number of independent ACHs, thereby making it impossible for them to satisfy the 25% rule despite no control or ability to direct or influence the admission patterns.

North Greenville Hospital questions the basis of the 25% threshold itself. CMS has presented no evidence to show that there is any statistical basis for applying such an arbitrary number throughout the country to penalize LTCHs.

Expanding the 25% rule to all LTCHs not only will jeopardize patients' access to appropriate medical care, but the significant and inappropriate financial losses it will generate will all but guarantee the closure of a significant number of LTCHs, thereby preventing access to these unique services by many Medicare beneficiaries.

While CMS's proposed expansion of the 25 percent rule (released January 25, 2007) contains a substantial qualitative analysis, it is silent on the crucial issue of **patient choice**. Patient choice is foundational to the Medicare and Medicaid programs. In fact, CMS guidance requires that healthcare providers offer Medicare beneficiaries and Medicaid recipients choice and requires providers to involve patients in decisions regarding their treatment. Furthermore accrediting standards of the Joint Commission state that patients have the right to be informed about and participate in decisions regarding their care; including discharge or transfer to another organization or level of care. By limiting the reimbursement to facilities under common control of the "host" facility, CMS is in effect limiting the choice of patients for long-term acute care.

The proposal to expand the 25% rule to grandfathered hospitals violates the statutory protection given to these hospitals by Congress in recognition of their unique status.

Extreme SSO policy

As noted above, the extreme SSO policy CMS is considering is contrary to clinical and financial realities. Under the current SSO policy a LTCH will at best receive only its cost for a SSO; there is no incentive for a LTCH to admit a patient who is likely to become a SSO. Under the extreme SSO policy being considered a LTCH would undoubtedly lose a significant sum on treating the patient.

Besides not having any financial incentive to admit an extreme SSO, CMS also assumes that LTCHs are able to predict, prior to admission, which patients will become SSOs, much less extreme SSOs. There is no way for LTCHs to make such a prediction. Long-term care hospital patients suffer from multi-system body failures with peaks and valleys in their medical conditions. Their conditions may unpredictability improve or deteriorate at any time. SSO cases are admitted to LTCHs at the appropriate level of care based on the medical judgment of their treating physicians. It is impossible to pre-screen patients and effectively identify which patients may become SSOs. There are a myriad of reasons why a patient admitted to an LTCH may become a SSO. Some SSO cases may achieve medical stability sooner than originally expected. Other cases may become SSOs because they require discharge to an acute hospital due to a deteriorating

condition or a new condition which develops subsequent to their admission to an LTCH. Other patients admitted to LTCHs from acute care hospitals may become SSO cases due to their unexpected death. Some patients and their families, after realizing the gravity of their condition, may simply give up and request that aggressive treatment be stopped after admission. Other patients may sign themselves out against medical advice.

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

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

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

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

In view of the foregoing North Greenville Hospital respectfully requests that CMS not expand the 25% rule to freestanding and grandfathered hospitals, and that it reject the extreme SSO policy under consideration.

Sincerely,

Michael L. Batchelor, Administrator

Submitter : Dr. Ted Epperly **Date:** 03/23/2007

Organization : Family Medicine Residency of Idaho

Category : Physician

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

Dear Sirs,

The 6 points that I would bring to your attention in regards to the CMS issue surrounding payment of Volunteer Preceptors are as follows :

1. I appreciate CMS's effort to define "All Substantially All" to a threshold of 90 %. However that threshold is still too high and needs to be reduced to 75 %.
2. CMS should allow for physician volunteerism that most if not all of our community physicians provide.
3. Allow programs / hospitals to exclude the costs of teaching physicians as part of the definition of "all or substantially all".
4. If the 3 hour precepting per week rule is used then that should be prorated for the number of clinics that the residents have with the preceptor per week (e.g. many of our residents come back to FP for their weekly clinics).
5. Hospitals / programs that are over their cap on residency slots as determined by BBA or BBRA have no duty to fulfill the requirements of this rule as the Medicare program is not paying for such training. That is certainly our case here in Idaho.
6. CMS has and will continue to adversely effect Family Medicine programs ability to train Family Physicians in community programs by having overly burdensome and onerous requirements for the use of community preceptors, none of whom see this as a problem.

Thanks you for your time on this issue.

Ted Epperly, MD

Submitter : **Ronald Grousky** **Date: 03/23/2007**

Organization : **Mayo Clinic**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1529-P-68-Attach-1.DOC

#68

March 23, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1529-P
P.O. Box 8017
Baltimore, Maryland 21244-8014

We appreciate the opportunity to comment on the Proposed Rule of February 1, 2007 regarding changes to the Direct and Indirect Graduate Medical Education Policy for non-provider settings. We offer the following comments for your consideration.

Teaching Physician

We agree with the defined three hours per week for the teaching physician's time, with the residents in non-billable activities. We currently conduct time studies which have been burdensome for all parties involved; this proposed rule would eliminate the arduous task.

Allowing an average salary, per program or specialty, for the teaching physician would be a feasible process for the calculation. We believe the RCE limits would be a more appropriate figure for the salaries since these limits are the required guidelines issued by CMS for reimbursement purposes. It is unclear why the RCE amounts would not be used. Nevertheless, if the proposed rule is finalized to use the American Medical Group Association's (AMGA) annual Medical Group Compensation and Financial Survey, we believe the median salary levels would be the most appropriate representation.

Effective Date

We agree that the effective date should be for cost reporting periods beginning on or after July 1, 2007 and not immediately effective for portions of cost reporting periods occurring on or after July 1, 2007. The process to account for two methods during one cost reporting year would be too cumbersome for providers.

Written Agreements

CMS states that written agreements must be in place prior to any resident's rotation to a non-providing setting and that the agreement must indicate that the hospital will incur at least 90 percent of the training costs and total compensation amount the hospital will incur to meet the 90 percent threshold. CMS further states that the agreement should state whether the amounts reflect only residents' stipends and benefits, or reflect the teaching physician costs as well. This language infers that the 90 percent criterion should be included in the agreement. We believe the requirements for hospitals to know the resident's program year level, specialty and salary and benefits for each rotation would be difficult prior to the agreement and residents rotation. We suggest that CMS provide more clarification on the specifics to be included and suggest a standard template for all hospitals to utilize.

Resident Costs

As stated in the proposed rule, the resident's costs can be easily identified. Our concern is the documentation that will be required at audit for each resident to prove that the 90 percent threshold has been satisfied. CMS needs more clarification as to what documentation and calculations will be needed by the providers. This could have a potential impact for accounting and become very cumbersome especially for providers who rotate many residents to non-provider settings each year. A schedule would need to be created to track these costs. We recommend CMS provide a standardized schedule, with calculations for all providers to utilize for proper documentation.

Thank you for the opportunity to comment on the proposed rule.

Very truly yours,

Ronald Grousky
Director, Medicare Strategy
Mayo Clinic

Submitter : **Mr. Edward Kalman** **Date: 03/23/2007**

Organization : **National Association of Long Term Hospitals**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment. Second Attachment to follow.

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

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

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

Submitter : Mr. Edward Kalman **Date:** 03/23/2007

Organization : National Assocation of Long Term Hosptials

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Attchment to NALTH's comment letter.

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

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

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

Submitter : Mr. Gregory Davis **Date:** 03/24/2007

Organization : Continental Rehabilitation Hospital of San Diego

Category : Hospital

Issue Areas/Comments

Other Proposed Policy Changes For The 2008 LTCh PPS Rate

Other Proposed Policy Changes For The 2008 LTCh PPS Rate

I believe the application of the 25% rule to frecstanding LTC hospitals is unreasonable. This hospital receives about 38% of its referrals from the closest hospital, a STAC with over 600 beds. The remaining referrals come from 17 other hospitals located throughout the county. Not surprisingly, the percentage of referrals by each hospital increases by the relative proximity to this LTAC.

Clearly patients will choose to obtain services at the location closest to their own community and for the same reasons they chose to seek care at the referring hospitals. The net effect of this rule will be to limit access to LTAC services in the patient s own community. This change is not only unfair to the LTAC provider community, but it also will unfairly impact Medicare beneficiaries.

In addition, the proposed change to the SSO rule complicates an already challenging change to the SSO rule that occurred within the past year. This assumes that the LTAC provider should be penalized for events that are clearly outside of anyone's control. For example, patients may be identified shortly after admission as having evidence of a new and unexpected complication related to the previous hospitalization. Treatment may require services that can only be provided by the referring STAC. Conversely, the patient may also experience sudden and dramatic improvement. Such events are nearly impossible to predict and yet this rule would penalize the LTAC when the unexpected happens. This seems very unfair.

Submitter : Mr. Peter Miller **Date:** 03/24/2007

Organization : Noland Health Services

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-1529-P-72-Attach-1.PDF

#72

NOLAND HEALTH SERVICES, INC.

March 23, 2007

BY ELECTRONIC FILING

Hon. Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1529-P
Mail Stop C4-26-5
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: ***Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes; Proposed Rule, 72 Fed. Reg. 4776 (February 1, 2007)***

Dear Ms. Norwalk:

This letter presents comments and recommendations of Noland Health Services, ("NHS") to certain aspects of the proposed annual payment rate updates and policy changes under the prospective payment system for long-term acute care hospitals ("LTACH PPS") for rate year ("RY") 2008, which were published by the Centers for Medicare & Medicaid Services ("CMS") on February 1, 2007.

NHS is a not-for-profit health care system headquartered in Birmingham, AL, that operates five (5) LTCH Hospital-in-a-Hospital ("HIH") hospitals located in Montgomery, Birmingham, Dothan, Anniston and Tuscaloosa, AL. NHS is a member of ALTHA, The Acute Long Term Association, and supports the comments made by ALTHA in their letter of March 23.

NHS is also the preeminent LTCH provider in the state of Alabama, with 71% of the state's LTCH hospitals. We have been providing LTCH care for almost 10 years, as part of our 94 year old not-for-profit mission. We are gravely concerned that the future of this mission is jeopardized by CMS' continued focus on arbitrary and capricious reimbursement changes, rather than addressing a rationalization of the need for this very special level of care for the small segment of Medicare beneficiaries who require extended acute care.

NHS opposes the arbitrary and inappropriate reductions in long-term care hospital ("LTACH") payments that will result if these proposed changes to the LTACH PPS are implemented. NHS has reviewed the proposed rule and agrees with ALTHA that it suffers from a number of recurring problems. First, as with other recent rulemakings affecting LTACHs, CMS continues to rely upon materially flawed and incomplete data in developing their proposed changes to LTACH payments for RY 2008. Second, NHS does not believe that CMS has seriously considered the legal and equitable issues which this proposed rule raises with regard to patient freedom of choice, physician medical decision-making, and the disparate impact on LTACHs in underserved areas.

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www.nolandhealth.com

NHS recommends that CMS reconsider its proposed changes to the LTACH PPS in light of the Medicare Payment Advisory Commission ("MedPAC") recommendations in June 2004 that the certification criteria for the Medicare LTACH provider category be strengthened to ensure that LTACH payments are being made to only those providers that are administering medically complex care to severely ill patients. NHS supports this approach as a more defined method for limiting LTACH payments to hospitals that are truly caring for a medically complex patient population. Unfortunately, the proposals that CMS advances in this proposed rule continue to rely on arbitrary and unproven payment reductions to achieve policy goals that are, in many cases, compatible with more comprehensive LTACH certification criteria but will not achieve those goals and will significantly hinder the ability of our LTCH's to continue to provide quality patient care to Medicare beneficiaries.

Noland Health Services strongly believes that arbitrary payment reductions are the wrong approach if quality of care is to be encouraged.

First and foremost, CMS should reconsider its proposed policy for extending the so-called "25% rule" from hospitals-within-hospitals ("HIH's") to all LTACH's, and its proposed policy to enlarge the category of short-stay outlier ("SSO") cases. To the extent that CMS is concerned about "inappropriate" admissions to LTACH's, it should implement more appropriate non-payment approaches such as pre-admission physician certifications, uniform admission screening criteria, and more extensive Quality Improvement Organization ("QIO") reviews. 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, NHS supports that goal. 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. Moreover, the cumulative effect of these policies will result in significantly reduced and even negative operating margins in our not-for-profit LTACH's. Establishing payment policies that reimburse Medicare providers below the cost of care violates a basic premise of the Medicare program.

The proposed rule takes the next step in a series of apparently calculated efforts by CMS to reverse the growth in the number of LTACH's and reduce reimbursement to LTACH's for caring for Medicare beneficiaries suffering from complex medical conditions that require long hospital stays. In continuing to reduce payment rates and expose additional LTACH cases to payment rates for short-term acute care hospitals ("STACH's"), CMS fails to account for prior adjustments to the LTACH PPS in the past few years that have had a great deal to due with the lack of growth of new LTACH's in Alabama. CMS's own data shows that growth in the number of LTACH's has stopped. According to the December 2006 CMS Provider of Service file, there was a net reduction of one LTACH in 2006. With regard to margins, MedPAC estimated LTACH margins to be at or near zero even before the proposed rule was released. A comprehensive analysis of the proposed rule reveals that LTACH margins will be between negative 3.7% and negative 5.7% if the proposed policies are finalized. This reduction in payment significantly below the cost of providing care will dramatically impact the ability of all LTCH's, as well as NHS's, to provide quality services to Medicare beneficiaries. CMS should not engage in this type of punitive rulemaking when Congress has provided express statutory authority for LTACH's and a PPS that reasonably reimburses LTACH's for the cost of care.

In the preamble to the proposed rule, CMS offers one primary justification in support of its two most significant policy proposals to extend the so-called "25% rule" from HIH's to all LTACH's and to enlarge the category of SSO cases: its belief that LTACH's are acting like units of STACH's, such that it believes that patients admitted to LTACH's are continuing the same episode of care that began during the patient's stay in the referring STACH. However, CMS fails to provide credible evidence that these interrelated issues are, in fact, occurring. CMS's own independent consultant, RTI International, has stated that the issue of LTACH's offering a continuation of a single episode of care is "poorly understood." The *opposite* is true – STACH's are not discharging patients to our LTACH's "early" and Medicare is *not* paying twice for a single episode of care. CMS's own data shows that LTACH patients have different characteristics than are evident during their preceding stay in a STACH. The data also shows that LTACH patients receive different treatments to address different clinical needs following a

stay in a STACH. Furthermore, differences in the medical complexity and average length of stay of LTACH cases substantiate reimbursement at the LTACH PPS rate, not the inpatient PPS rate for STACH's. CMS also has not presented evidence that LTACH's are acting like units of general acute care hospitals. The existence of primary referral and discharge relationships between our LTACH's and STACH's are both required by law and necessary to facilitate quality patient care in the most appropriate patient care setting.

NHS has serious concerns about a number of unintended consequences associated with CMS's proposal to expand the 25% rule to freestanding LTACH's and grandfathered LTACH HIH's and satellite facilities. CMS is proposing to expand the existing payment limitation threshold to any LTACH or satellite of an LTACH that discharges during a single cost reporting period more than 25% (or applicable percentage for rural, single-urban, or MSA-dominant hospitals) of Medicare patients admitted from any non-co-located individual hospital. The original 25% rule was adopted by CMS in regulations that were recently published on August 11, 2004 and have yet to be fully implemented. Until the existing 25% rule is fully implemented, it is impossible to know the full impact of the existing rule on LTACH's and the impact that rule is having on patient access and quality of care for Medicare beneficiaries. What we do know is that the existing 25% rule, in combination with CMS's other payment policies has reduced growth in the net number of new LTACH's to negative numbers. Yet CMS is advancing a policy that, without question, will further restrict patient choice and diminish access to quality care by imposing a rigid, arbitrary, and extremely limiting quota on the number patients who will be fairly reimbursed at the LTACH PPS rates.

Further, limitations on the number of patients admitted from a single hospital severely undermine physician judgment to determine what clinical setting is in the best interest of the patient. Through its other policies, CMS has repeatedly reinforced a patient's right to choose a health care provider. But this proposed policy will have a discriminatory impact on LTACH's and Medicare beneficiaries. For no clinical reason, patients in the 26th percentile and higher will be paid like general acute care patients when their complex medical needs and relatively long stays require LTACH care. The LTACH's that we operate that are located in underserved areas or communities with less than four general acute care hospitals where LTACH's lack the ability to offset reduced patient referrals from one hospital with a greater number of LTACH-level patients from other hospitals will be extremely negatively impacted by this rule. These results have nothing to do with the care required by a particular patient or the quality of care offered by a particular LTACH, and has everything to do with the unintended consequences that will result from the arbitrary nature of establishing a payment limitation that has no relevance to patient or facility level criteria. For these reasons, the proposed rule not only penalizes us and other LTACH providers, it penalizes all Medicare beneficiaries.

NHS is concerned that CMS has set forth yet another proposal to expand the class of SSOs that would effectively be paid at STACH rates without understanding the types of patients that would be treated as SSOs under the proposed policy. In the proposed rule, CMS indicates that it is considering lowering LTACH payment to the IPPS rate for cases with a length of stay that is less than the average length of stay plus one standard deviation for the same DRG under IPPS. Cases with a covered length of stay less than or equal to one standard deviation for the same DRG under IPPS would be paid at an amount comparable to the IPPS per diem.

As noted above, CMS offers the same justification for this short stay policy as is offered for the 25% rule policy. CMS believes that LTACH patients with "very short" lengths of stay have not completed their "episode of care" and should not have left the STACH. CMS's own data provides no support for this "belief." Moreover, rather than capture truly short-stay patients with lengths of stay that approximate STACH patient lengths of stay, as suggested, this policy would actually have the perverse effect of treating as SSOs many LTACH patients with lengths of stay that approach the 25-day average for LTACH certification (*e.g.*, 21 days, 23 days). NHS strongly encourages CMS not to make further changes in the SSO policy based upon the data provided herein and because MedPAR data is not available yet to evaluate whether the SSO policy changes put into effect last year are achieving the

desired policy goals. CMS has produced no study or analysis in the proposed rule showing that inappropriate admissions constitute a material portion of SSO cases. To the contrary, the opposite is true: SSO cases are, in fact, appropriate for admission to LTACH's for a number of reasons, including the fact that even shorter stay LTACH's patients are more severely ill than comparable STACH patients; difficulty in screening SSOs from admission to LTACH's based upon clinical criteria at the time of discharge from the referring hospital; the inability of clinicians to predict when LTACH patients will expire; and the inherent averaging of patient lengths of stay that is the foundation of the current LTACH certification criteria and PPS. If the patient meets InterQual admission criteria, and can be reasonable expected to stay for an extended period of time, and a physician admits the patient, the LTCH should not be so severely financially penalized that negative operating margins are created. 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. It would seem that CMS would be aware that the rate of payment for these cases will be insufficient to cover NHS's and other LTCH's reasonable and necessary costs in providing care to this segment of LTACH patients.

The proposed policies violate the statutory requirement that CMS reimburse LTACH's on a per discharge basis that reflects the reasonable and necessary cost of providing services in a hospital having an *average* length of stay of greater than 25 days. The proposed policies will continue to erode the LTACH PPS by reimbursing LTACH's for fewer and fewer medically complex patients at the LTACH PPS rates. The LTACH PPS must adequately reimburse LTACH's for the costs they incur in caring for Medicare beneficiaries. The cumulative effect of the proposed changes to the LTACH PPS will be to bring LTACH reimbursement below the cost of care. This level of reimbursement is unsustainable and will inevitably result in a decrease in access to LTACH services in spite of the increasing number of Medicare beneficiaries and the overall aging of the country's population. The Congress, the LTACH industry, MedPAC, and RTI International all agree that LTACH's serve an important role in caring for medically complex patients who need long-term hospital stays. CMS should develop policies that reflect this consensus. We encourage CMS to work with the Congress to develop meaningful facility and patient certification criteria for LTACH's, as proposed in H.R. 562 and S. 338.

NHS objects to CMS's proposal to provide less than the full market basket update of 3.2% for RY 2008. An increase of less than the market basket will not account for the cost of goods and services required to deliver LTACH services and will result in rates below the cost of care. The full market basket update is an accurate reflection of items and services purchased to treat Medicare beneficiaries and is necessary to account for the rising cost of inputs. The federal rate must be updated in accordance with the market basket to keep LTACH payment rates in step with the higher cost of price inputs.

In summary, NHS urges CMS to carefully consider the comments and data provided in this letter and to reexamine the policies advanced in the proposed rule. The types of patients admitted to LTACH's, the care provided during an LTACH stay, and the relationships that LTACH's have with STACH's show that Medicare is not paying twice for a single episode of care. LTACH's serve a distinct and important purpose in the health care continuum. Noland's LTCH's are vital to the mission of NHS, of meeting unmet healthcare needs for an underserved population in Alabama. CMS's payment policies should reflect this in a manner that fairly compensates LTACH's for the care they provide to thousands of Medicare beneficiaries in Alabama and across the nation.

Sincerely,

Peter J. Miller, Vice President
Noland Health Services

Submitter : **Dr. James Mongan** **Date: 03/25/2007**

Organization : **Partners Healthcare Inc**

Category : ***Health Care Provider/Association***

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1529-P-73-Attach-1.DOC

CMS-1529-P-73-Attach-2.DOC

#73

Via E-Rulemaking

March 26, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: CMS-1529-P

Dear Ms. Norwalk:

Partners HealthCare System, Inc. appreciates the opportunity to provide comments on the Prospective Payment System for Long Term Care Hospitals: RY 2008 Proposed Annual Payment Rate Updates and Policy Changes, and Clarification, Proposed Rule, as published in the February 1, 2007 Federal Register.

We offer these comments on behalf of our member hospital Shaughnessy-Kaplan Rehabilitation (SKRH), a Long Term Care Hospital and integral component of our Integrated Delivery System. Importantly, we also offer these comments on behalf of our acute care hospitals[1] that will also be affected by this rule. Finally, we offer these comments from our thirteen-year perspective as an integrated delivery system that has continually strived to ensure that care throughout our system is "the right care, at the right place, at the right time."

Expansion of 25% Rule

We strongly oppose CMS proposal to extend the 25% rule to all subclause (I) LTCHs and LTCH grandfathered Hospital-Within-Hospitals. At the outset, we acknowledge CMS continued concern that Medicare beneficiaries receive care in the most appropriate setting. We share this concern. However, we strongly believe that extending the 25% rule is not the way to ensure this, and in fact, will prevent beneficiaries from receiving care in the most appropriate setting.

Clinically, this proposal will have a number of unintended consequences

[1] Partners HealthCare System Acute Care Hospitals: Brigham and Women's Hospital, Faulkner Hospital, Massachusetts General Hospital, Newton Wellesley Hospital, North Shore Medical Center.

- It will arbitrarily restrict beneficiary access to the effective, multi-disciplinary care that LTCHs provide. LTCHs, particularly long-standing institutions like SKRH, have painstakingly gathered highly skilled clinicians in a mix of medical specialties and disciplines along with the necessary support services to meet ***all the needs*** of patients requiring long term care. The proposed expansion of the 25% rule will literally establish a first-come, first serve queue of Medicare beneficiaries. ***This analogy cannot be understated:*** for LTCH "A" treating 100 Medicare patients a year and 40 from one referral hospital, CMS would walk down the line of 40, stop at the 25th patient and say to the remaining 15 – you must get your care elsewhere, regardless of whether LTCH A is the most appropriate place for you.
- It will disrupt established patterns of care – in the case of SKRH, 32 years of established care. Beneficiaries will be faced with two unwelcome choices: either remain in the acute hospital longer than is medically necessary and/or appropriate, or receive care at another LTCH very likely considerably farther away from your family and support network..
- It will extend stays in the acute care hospital, thereby:
    - Forcing beneficiaries to either forego or, at best, delay receiving the optimal combination of services that LTCH's provide.
    - Forcing acute hospitals to substantially increase cost to build a program of services provided in LTCHs.
    - Tieing up acute care beds better suited for more severely ill beneficiaries, resulting in beneficiaries receiving care in other unfamiliar hospitals or delaying elective admissions.

Financially, this will have a devastating impact on SKRH, reducing Medicare payments by up to $4M a year, equal to 20 percent of Medicare payments and 10 percent of SKRH's total patient revenue. An abrupt reduction of this magnitude would, in unequivocal terms, threaten the very existence of SKRH.

The proposed expansion of the 25% rule will have significant adverse impact on our acute care hospitals. Our acute hospitals are specifically resourced to provide short stay, acute level care. In the proposed rule, CMS notes one fundamental principle of PPS, i.e., that the payment amount exceeds cost in some cases, lags cost in others with the intent that, overall, payments cover the cost of an efficient provider. Yet this proposed rule will run counter to this fundamental rule: Extending the acute length of stay solely for administrative reasons (i.e., LTCHs will very likely refuse to accept certain patients from acute hospitals, thereby increasing their acute hospital stay), as this proposed rule will do, ***is not an efficient use*** of acute hospital resources. Even more importantly, CMS states its concern that acute care hospitals are avoiding the costs of outlier stays by inappropriate discharging of patients to LTCHs. The average acute care hospital, as measured by MedPAC, is already losing money under Medicare.[2] Yet, the proposed expansion of the 25% rule will drive up costs for acute care hospitals, further deteriorating acute hospital margins and forcing acute hospitals to cross subsidize these

[2] Average Medicare inpatient margin for acute hospitals in 2005 was –0.9 percent, per MedPAC Report to Congress, March, 2007.

larger losses through higher payments from private payers that are pushing back harder and harder against such cross-subsidization.

Ethically and administratively, the proposed rule would create significant difficulties: The reduction in payment for every patient over the threshold is so significant that LTCHs will be forced to monitor both the "numerator" and "denominator" of the threshold calculation literally on a daily basis. First of all, determining the numerator "in real time" will be very difficult: How will a LTCH know if each patient from an acute hospital qualified for outlier payments when it is very difficult for the acute hospital to make that precise determination? Of more concern to us is that LTCHs will be forced into a very uncomfortable, almost daily, dilemma:

- Payment reductions under IPPS will be as much as $20,000 per case. At this magnitude, LTCH staff will have a fiduciary responsibility to the overall institution and all of its patients to keep a very tight rein on the number of patients it can accept from each referring hospital – it simply cannot afford to run up a deficit.
- On the other hand, every LTCH feels a responsibility to accept all beneficiaries that will benefit from the services it provides. Quite frankly, when faced with the decision whether or not to accept the next patient from Referral Hospital "B", which already has, say, 28 percent of the LTCH's Medicare discharges so far that year, the LTCH will likely choose to put itself in more financial jeopardy, trusting that it can work harder to solicit admissions from other Referral Hospitals, thereby increasing its denominator and therefore reducing the percentage of Medicare admissions from Referral Hospital "B".

As we stated above, we share CMS' concern that discharges to an LTCH should be based solely on medical reasons, not financial gain. Yet, the way to ensure this medical outcome is through medical action, not financial action. There is, we maintain, only one way to fairly and objectively ensure that the beneficiaries admitted to LTCHs are there because it is the most appropriate site of care for them: through well-thought out patient clinical criteria. MedPAC, in its recommendation on Long Term Care payment policy (March 2004 Annual Report to Congress) stated:

> ***"Long-term care hospitals should be delineated by facility and patient characteristics that ensure that patients admitted to these facilities are medically complex and have a good chance of improvement and cannot be treated in other less costly settings"***

We again reiterate that we are adamantly opposed to the proposed expansion of the 25% rule – it's use as a "tool" to ensure that all LTCH services received by Medicare beneficiaries add value and are not simply replacing services the beneficiary "should have" obtained in an acute hospital or other setting is akin to performing delicate surgery with a blunt instrument – it will have unintended consequences. The proper tool, as we state above, is a precise combination of patient and facility characteristics. In recognition of CMS ongoing concern, however, we suggest a ***temporary, limited*** expansion of the threshold while patient and facility characteristics are developed and implemented. Specifically, we recommend a three-year, temporary and limited expansion of the threshold to freestanding LTCHs and grandfathered LTCH Hospital-within-Hospitals:

- Year one: 75 percent threshold
- Year two: 62.5 percent
- Year three: 50 percent

This expansion would sunset after year 3, at which time it would be replaced permanently with patient and facility characteristics.

In addition, we recommend that this temporary expansion of the threshold be applied on the basis of location, not provider number. This is of great concern to SKRH. In reading the proposed rule carefully, we were confident that the threshold would be applied based on location, i.e., of the individual campus, rather than by provider number. Judy Richter of CMS confirmed this in a conversation she had with Anthony Santangelo and Cecelia Wu, members of the Partners Finance staff. We were greatly concerned to learn that other staff within CMS had a different view, i.e., that the threshold would be applied by provider number. A hospital with two campuses and a single provider number usually has two separate patient populations in two different communities. It would be unreasonable to count this as one hospital. This would also be more severe than the location-based policy of co-located LTCHs established in the prior 25% rule. CMS intent, we believe, is clearly proximity – given this, only application of the threshold by location would be consistent with this intent.

Conclusion

In closing, we urge CMS to withdraw its proposal to expand the 25 percent rule to freestanding LTCHs and LTCH grandfathered Hospital-Within-Hospitals. Such an expansion will have a devastating impact on Shaughnessy-Kaplan Rehabilitation Hospital and many other LTCHs as well. For some, including SKRH, the impact may be so great that the hospital would have no choice but to significantly reduce services in order to survive. This action will adversely affect some beneficiaries, arbitrarily denying them access to the most appropriate care for their medical and psychosocial needs. Instead, we urge CMS to redouble its efforts to establish and implement new long term care hospital facility and patient screening criteria. It is only through objective and well-thought out criteria, we believe, that CMS will truly be successful in ensuring that only appropriate patients receive care in a LTCH.

Please contact Anthony Santangelo, Corporate Manager, Government Revenue, should you or your staff have any questions or would like additional information. Mr. Santangelo can be reached via email at asantangelo@partners.org or by phone at (617) 726-5449.

Sincerely,

James J. Mongan
President and CEO
Partners HealthCare System, Inc.
Boston, MA

Submitter : Dr. Sam Cullison **Date:** 03/25/2007

Organization : Dr. Sam Cullison

Category : Physician

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

I am the residency training director for the Swedish Medical Center Family Medicine residency in Seattle WA. We have 30 resident doctors in training at three community sites, where each year we graduate 10 doctors who then enter practice in the community, primarily working with multi-ethnic underserved and economically disadvantaged patient populations. In many specialties of medicine, training is primarily hospital based and provided by program sponsor physicians only in the specialty of training (all specialties of surgery-general, vascular, neurosurgery, etc, as well as pathology, radiology, on so on). In Family Medicine, nearly 60% of the training is outpatient based, and nearly half of that is provided by community teachers in private practice who are not Family Physicians themselves: dermatology, ear/nose/throat, orthopedics, urology, and so on. WE use in our Family Medicine program community preceptors from these and other specialties throughout the 3 years of training. The number of specific instructors who willingly volunteer their time to train our residents is 18, with some practicing in community health centers, some in private practice, some in practices sponsored/owned by our hospital and some in other unique settings such as the military. All of these individuals provide their teaching efforts without expectation nor desire for payment. We are able to provide them clinical teaching appointments, which entitles them to many benefits through our university affiliation with the University of Washington, most partieularly access to web based medical reference materials not avialable to the general public without payment of subscriptions worth many thousands of dollars. However, though the teachers do reeeive and valuc access to these very important information sources, they primarily provide their time to teach based on the long standing medical tradition of training the next generation of physicians. Didactic teaching is provided to our residents in two ways: we provide a half day of conference time weekly, where full/part time faculty, residents themselves and community speakers present at this forum. In addition, brief moments of teaching are provided at the bedside/clinic exam room & hallway during the course of provision of medical care throughout the each and every day of training time. All of these latter incidents of teaching are brief, opportunistic and unscripted. They amount to minutes per week only, very difficult to track or monitor, yet critical to quality training as they are directly related to the patient at the moment of care. The complex rules advocated as the "solution" to payment for community teaching will be catastrophie for our residency program, and viewed as desirable by no one currently involved in our residents education. The community teachers are neither supportive nor desirous of the proposed changes. They view the acquisition of the needed information to provide payments to them (how much they earn annually, the financial structure of their practice, the amount of time they spend teaching residents when not with patients) as intrusive and burdensome. They gladly teach for free and seek no payment for this service, though they welcome the medical information access mentioned above. The residency program, though very successful in attracting ourstanding residents from the some of the very best medical schools in the US, like all of primary care in this country is run on a "shoe string" budget with no extra funding available for additional expenses. At least, if these new training rules go into effect, we will need to cease working with many of the best community preceptors and limit the teaching to employed doctors working for our hospital. Hoever, the doctors we currently work with have been those identified as the best teachers by our resident learners. CMS rules should allow community doctors to volunteer, The all or substantially all rule should have a 75% threshold

Submitter : **Dr. Colleen Buchinger** **Date: 03/25/2007**

Organization : **The Liberty CLinic**

Category : **Physician**

Issue Areas/Comments

Background

Background

I have a concern reguarding the 25% rule. I work in Liberty, Missouri. Liberty Hospital and North Kansas CIty Hospital have joined together to open a LTAC. It will be the only one north of the river in Kansas City. Currently our patients have to be sent South of town for long term care, and out of their primary doctors care. By opening an LTAC nearby we will be able to continue to care for our patients during this transition. My concern with the 25% rule is that we will again have to send our patients SOuth of the river toward the end of the year if the 25% from one hospital has benn reached. ALready we sometimes have trouble getting our patients into LTAC settings, this is why the medical staff of both hospitals supported the joint venture. I feel close consideration has to be made before applying this rule to all LTAC setting, because patients may suffer because of having to go further away from their families and primary doctors just to satisfy a rule.

Submitter : Mr. Xavier Ritchie **Date:** 03/26/2007

Organization : Long Term Hospital of Birmingham

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1529-P-76-Attach-1.PDF

Long Term Hospital of Birmingham

March 23, 2007

BY ELECTRONIC FILING

Hon. Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1529-P
Mail Stop C4-26-5
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: ***Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes; Proposed Rule, 72 Fed. Reg. 4776 (February 1, 2007)***

Dear Ms. Norwalk:

This letter presents comments and recommendations of Noland Health Services, ("NHS") to certain aspects of the proposed annual payment rate updates and policy changes under the prospective payment system for long-term acute care hospitals ("LTACH PPS") for rate year ("RY") 2008, which were published by the Centers for Medicare & Medicaid Services ("CMS") on February 1, 2007.

NHS is a not-for-profit health care system headquartered in Birmingham, AL, that operates five (5) LTCH Hospital-in-a-Hospital ("HIH") hospitals located in Montgomery, Birmingham, Dothan, Anniston and Tuscaloosa, AL. NHS is a member of ALTHA, The Acute Long Term Association, and supports the comments made by ALTHA in their letter of March 23.

NHS is also the preeminent LTCH provider in the state of Alabama, with 71% of the state's LTCH hospitals. We have been providing LTCH care for almost 10 years, as part of our 94 year old not-for-profit mission. We are gravely concerned that the future of this mission is jeopardized by CMS' continued focus on arbitrary and capricious reimbursement changes, rather than addressing a rationalization of the need for this very special level of care for the small segment of Medicare beneficiaries who require extended acute care.

Long Term Hospital of Birmingham located in Birmingham, Alabama is proud to continue the long standing tradition of Noland Health Services, by providing LTACH services to the elderly and underserved citizens of north central Alabama. The facility is in its fourth year of operation and has provided hospital care to 932 patients with multiple complex diagnosis usually compounded by other chronic condition. We have experienced very good patient outcomes, which includes a seventy three percent (73%) ventilator wean success rate, well above the national average. The facility has met the healthcare needs of patients, families, and our community. These complex patients need the ability and

the option of patient access to the types of service needed for improvement, recovery, and the increase in quality of life.

NHS opposes the arbitrary and inappropriate reductions in long-term care hospital ("LTACH") payments that will result if these proposed changes to the LTACH PPS are implemented. NHS has reviewed the proposed rule and agrees with ALTHA that it suffers from a number of recurring problems. First, as with other recent rulemakings affecting LTACHs, CMS continues to rely upon materially flawed and incomplete data in developing their proposed changes to LTACH payments for RY 2008. Second, NHS does not believe that CMS has seriously considered the legal and equitable issues which this proposed rule raises with regard to patient freedom of choice, physician medical decision-making, and the disparate impact on LTACHs in underserved areas.

NHS recommends that CMS reconsider its proposed changes to the LTACH PPS in light of the Medicare Payment Advisory Commission ("MedPAC") recommendations in June 2004 that the certification criteria for the Medicare LTACH provider category be strengthened to ensure that LTACH payments are being made to only those providers that are administering medically complex care to severely ill patients. NHS supports this approach as a more defined method for limiting LTACH payments to hospitals that are truly caring for a medically complex patient population. Unfortunately, the proposals that CMS advances in this proposed rule continue to rely on arbitrary and unproven payment reductions to achieve policy goals that are, in many cases, compatible with more comprehensive LTACH certification criteria but will not achieve those goals and will significantly hinder the ability of our LTCH's to continue to provide quality patient care to Medicare beneficiaries.

Noland Health Services strongly believes that arbitrary payment reductions are the wrong approach if quality of care is to be encouraged.

First and foremost, CMS should reconsider its proposed policy for extending the so-called "25% rule" from hospitals-within-hospitals ("HIH's") to all LTACH's, and its proposed policy to enlarge the category of short-stay outlier ("SSO") cases. To the extent that CMS is concerned about "inappropriate" admissions to LTACH's, it should implement more appropriate non-payment approaches such as pre-admission physician certifications, uniform admission screening criteria, and more extensive Quality Improvement Organization ("QIO") reviews. 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, NHS supports that goal. 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. Moreover, the cumulative effect of these policies will result in significantly reduced and even negative operating margins in our not-for-profit LTACH's. Establishing payment policies that reimburse Medicare providers below the cost of care violates a basic premise of the Medicare program.

The proposed rule takes the next step in a series of apparently calculated efforts by CMS to reverse the growth in the number of LTACH's and reduce reimbursement to LTACH's for caring for Medicare beneficiaries suffering from complex medical conditions that require long hospital stays. In continuing to reduce payment rates and expose additional LTACH cases to payment rates for short-term acute care hospitals ("STACH's"), CMS fails to account for prior adjustments to the LTACH PPS in the past few years that have had a great deal to due with the lack of growth of new LTACH's in Alabama. CMS's own data shows that growth in the number of LTACH's has stopped. According to the December 2006 CMS Provider of Service file, there was a net reduction of one LTACH in 2006. With regard to margins, MedPAC estimated LTACH margins to be at or near zero even before the proposed rule was released. A comprehensive analysis of the proposed rule reveals that LTACH margins will be between negative 3.7% and negative 5.7% if the proposed policies are finalized. This reduction in payment significantly below the cost of providing care will dramatically impact the ability of all LTCH's, as well as NHS's, to provide quality services to Medicare beneficiaries. CMS should not

engage in this type of punitive rulemaking when Congress has provided express statutory authority for LTACH's and a PPS that reasonably reimburses LTACH's for the cost of care.

In the preamble to the proposed rule, CMS offers one primary justification in support of its two most significant policy proposals to extend the so-called "25% rule" from HIH's to all LTACH's and to enlarge the category of SSO cases: its belief that LTACH's are acting like units of STACH's, such that it believes that patients admitted to LTACH's are continuing the same episode of care that began during the patient's stay in the referring STACH. However, CMS fails to provide credible evidence that these interrelated issues are, in fact, occurring. CMS's own independent consultant, RTI International, has stated that the issue of LTACH's offering a continuation of a single episode of care is "poorly understood." The *opposite* is true – STACH's are not discharging patients to our LTACH's "early" and Medicare is *not* paying twice for a single episode of care. CMS's own data shows that LTACH patients have different characteristics than are evident during their preceding stay in a STACH. The data also shows that LTACH patients receive different treatments to address different clinical needs following a stay in a STACH. Furthermore, differences in the medical complexity and average length of stay of LTACH cases substantiate reimbursement at the LTACH PPS rate, not the inpatient PPS rate for STACH's. CMS also has not presented evidence that LTACH's are acting like units of general acute care hospitals. The existence of primary referral and discharge relationships between our LTACH's and STACH's are both required by law and necessary to facilitate quality patient care in the most appropriate patient care setting.

NHS has serious concerns about a number of unintended consequences associated with CMS's proposal to expand the 25% rule to freestanding LTACH's and grandfathered LTACH HIH's and satellite facilities. CMS is proposing to expand the existing payment limitation threshold to any LTACH or satellite of an LTACH that discharges during a single cost reporting period more than 25% (or applicable percentage for rural, single-urban, or MSA-dominant hospitals) of Medicare patients admitted from any non-co-located individual hospital. The original 25% rule was adopted by CMS in regulations that were recently published on August 11, 2004 and have yet to be fully implemented. Until the existing 25% rule is fully implemented, it is impossible to know the full impact of the existing rule on LTACH's and the impact that rule is having on patient access and quality of care for Medicare beneficiaries. What we do know is that the existing 25% rule, in combination with CMS's other payment policies has reduced growth in the net number of new LTACH's to negative numbers. Yet CMS is advancing a policy that, without question, will further restrict patient choice and diminish access to quality care by imposing a rigid, arbitrary, and extremely limiting quota on the number patients who will be fairly reimbursed at the LTACH PPS rates.

Further, limitations on the number of patients admitted from a single hospital severely undermine physician judgment to determine what clinical setting is in the best interest of the patient. Through its other policies, CMS has repeatedly reinforced a patient's right to choose a health care provider. But this proposed policy will have a discriminatory impact on LTACH's and Medicare beneficiaries. For no clinical reason, patients in the 26th percentile and higher will be paid like general acute care patients when their complex medical needs and relatively long stays require LTACH care. The LTACH's that we operate that are located in underserved areas or communities with less than four general acute care hospitals where LTACH's lack the ability to offset reduced patient referrals from one hospital with a greater number of LTACH-level patients from other hospitals will be extremely negatively impacted by this rule. These results have nothing to do with the care required by a particular patient or the quality of care offered by a particular LTACH, and has everything to do with the unintended consequences that will result from the arbitrary nature of establishing a payment limitation that has no relevance to patient or facility level criteria. For these reasons, the proposed rule not only penalizes us and other LTACH providers, it penalizes all Medicare beneficiaries.

NHS is concerned that CMS has set forth yet another proposal to expand the class of SSOs that would effectively be paid at STACH rates without understanding the types of patients that would be treated as SSOs under the proposed policy. In the proposed rule, CMS indicates that it is considering

lowering LTACH payment to the IPPS rate for cases with a length of stay that is less than the average length of stay plus one standard deviation for the same DRG under IPPS. Cases with a covered length of stay less than or equal to one standard deviation for the same DRG under IPPS would be paid at an amount comparable to the IPPS per diem.

As noted above, CMS offers the same justification for this short stay policy as is offered for the 25% rule policy. CMS believes that LTACH patients with "very short" lengths of stay have not completed their "episode of care" and should not have left the STACH. CMS's own data provides no support for this "belief." Moreover, rather than capture truly short-stay patients with lengths of stay that approximate STACH patient lengths of stay, as suggested, this policy would actually have the perverse effect of treating as SSOs many LTACH patients with lengths of stay that approach the 25-day average for LTACH certification (*e.g.*, 21 days, 23 days). NHS strongly encourages CMS not to make further changes in the SSO policy based upon the data provided herein and because MedPAR data is not available yet to evaluate whether the SSO policy changes put into effect last year are achieving the desired policy goals. CMS has produced no study or analysis in the proposed rule showing that inappropriate admissions constitute a material portion of SSO cases. To the contrary, the opposite is true: SSO cases are, in fact, appropriate for admission to LTACH's for a number of reasons, including the fact that even shorter stay LTACH's patients are more severely ill than comparable STACH patients; difficulty in screening SSOs from admission to LTACH's based upon clinical criteria at the time of discharge from the referring hospital; the inability of clinicians to predict when LTACH patients will expire; and the inherent averaging of patient lengths of stay that is the foundation of the current LTACH certification criteria and PPS. If the patient meets InterQual admission criteria, and can be reasonable expected to stay for an extended period of time, and a physician admits the patient, the LTCH should not be so severely financially penalized that negative operating margins are created. 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. It would seem that CMS would be aware that the rate of payment for these cases will be insufficient to cover NHS's and other LTCH's reasonable and necessary costs in providing care to this segment of LTACH patients.

The proposed policies violate the statutory requirement that CMS reimburse LTACH's on a per discharge basis that reflects the reasonable and necessary cost of providing services in a hospital having an *average* length of stay of greater than 25 days. The proposed policies will continue to erode the LTACH PPS by reimbursing LTACH's for fewer and fewer medically complex patients at the LTACH PPS rates. The LTACH PPS must adequately reimburse LTACH's for the costs they incur in caring for Medicare beneficiaries. The cumulative effect of the proposed changes to the LTACH PPS will be to bring LTACH reimbursement below the cost of care. This level of reimbursement is unsustainable and will inevitably result in a decrease in access to LTACH services in spite of the increasing number of Medicare beneficiaries and the overall aging of the country's population. The Congress, the LTACH industry, MedPAC, and RTI International all agree that LTACH's serve an important role in caring for medically complex patients who need long-term hospital stays. CMS should develop policies that reflect this consensus. We encourage CMS to work with the Congress to develop meaningful facility and patient certification criteria for LTACH's, as proposed in H.R. 562 and S. 338.

NHS objects to CMS's proposal to provide less than the full market basket update of 3.2% for RY 2008. An increase of less than the market basket will not account for the cost of goods and services required to deliver LTACH services and will result in rates below the cost of care. The full market basket update is an accurate reflection of items and services purchased to treat Medicare beneficiaries and is necessary to account for the rising cost of inputs. The federal rate must be updated in accordance with the market basket to keep LTACH payment rates in step with the higher cost of price inputs.

In summary, NHS urges CMS to carefully consider the comments and data provided in this letter and to reexamine the policies advanced in the proposed rule. The types of patients admitted to LTACH's, the care provided during an LTACH stay, and the relationships that LTACH's have with STACH's show that Medicare is not paying twice for a single episode of care. LTACH's serve a

distinct and important purpose in the health care continuum. Noland's LTCH's are vital to the mission of NHS, of meeting unmet healthcare needs for an underserved population in Alabama. CMS's payment policies should reflect this in a manner that fairly compensates LTACH's for the care they provide to thousands of Medicare beneficiaries in Alabama and across the nation.

Sincerely,

Xavier Ritchie, Administrator
Long Term Hospital of Birmingham

Submitter : Mr. Rick Pollack **Date:** 03/26/2007

Organization : American Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1529-P-77-Attach-1.DOC

#11

American Hospital Association

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March 26, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

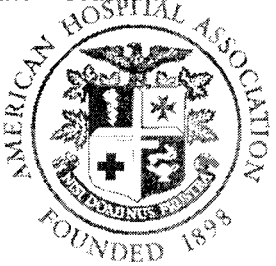
RE: (CMS–1529–P) Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes, (Vol. 72, No. 21), February 1, 2007

Dear Ms. Norwalk:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed changes to the long-term care hospital (LTCH) prospective payment system (PPS). We are troubled by CMS' proposed expansion of the 25% Rule on patient referral source, changes to the short-stay outlier policy and an offset for coding changes. However, we support the move to re-weight the LTCH diagnosis-related groups (DRGs) in a budget-neutral manner.

EXPANSION OF THE 25% RULE TO FREESTANDING AND GRANDFATHERED LTCHS

In its fiscal year (FY) 2005 rule, CMS implemented payment limitations for LTCHs that are co-located with other hospitals in response to concerns about "inappropriate patient shifting" between acute care hospitals and LTCHs. Under the rule, when an LTCH is co-located with another hospital, no more that 25 percent of the LTCH's admissions from the co-located hospital will be paid at the full LTCH prospective payment rate. If the LTCH receives more than 25 percent of its admissions from the co-located hospital, the LTCH payments will be reduced for those patients exceeding the limit. CMS adopted the 25% Rule, in part, to address its concern that locating an LTCH within an acute care hospital might encourage the shifting of patients from host hospitals to co-located LTCHs for financial – rather than medically appropriate – reasons.



As part of its annual LTCH PPS payment update for 2008, CMS proposes to extend the 25% Rule to all LTCHs, including freestanding and satellite facilities, as well as LTCHs that were exempted from the original 25% Rule. To accommodate LTCHs located in rural areas or in metropolitan statistical areas (MSAs) served by one or more "MSA dominant hospitals" (i.e., hospitals that generate more than 25 percent of the Medicare discharges in the MSA), the agency increases the referral limitation to 50 percent. However, this move falls short of addressing the unique needs of most LTCHs and the general acute care hospitals that rely on them as part of their community's health care continuum.

As with the existing 25% Rule application, CMS' proposed expansion to all LTCHs lacks any meaningful relationship to the clinical appropriateness of LTCH admissions. LTCHs provide intense care to patients who require longer lengths of stay than a typical patient in an inpatient hospital, such as those on ventilators or burn victims. Any proposed policy regarding LTCHs should ensure access for patients for whom LTCH care is medically appropriate– a view supported by the Medicare Payment Advisory Commission. CMS is making payment decisions based on an arbitrary percentage. Last year, CMS released a report by the Research Triangle Institute (RTI) that identified feasible patient and facility criteria that would help distinguish LTCHs from other acute care facilities. However, CMS has not yet used the report to produce specific policy recommendations.

Rather than limiting access to LTCH services through payment cuts, we urge CMS not to move forward with the proposed rule, but to work with the RTI and LTCH providers to develop appropriate facility and patient-centered criteria to determine the types of patients that should be treated in LTCHs.

SHORT-STAY OUTLIERS

The LTCH short-stay outlier policy applies to cases with a length of stay up to 5/6 of the geometric mean length of stay for a particular diagnosis. In rate year (RY) 2007, CMS modified the LTCH short-stay outlier policy by adding the fourth payment alternative described below; as a result, Medicare payments to LTCHs were reduced by an estimated $156 million. Currently, short-stay outlier cases are paid the lesser of four payment alternatives:

- 100 percent of patient costs;
- 120 percent of the per diem of the LTCH DRG payment;
- the full LTCH DRG payment; or
- a blend of the general hospital inpatient PPS per diem and 120 percent of the LTCH PPS per diem. As a patient's length of stay increases, the LTCH DRG portion of the blend increases.

CMS' analysis of FY 2005 MedPAR data shows that 42 percent of LTCH short-stay outlier cases had lengths of stay that were less than or equal to the comparable length of stay (plus one standard deviation) for general acute care hospitals. Further data analysis shows that for ventilator and ventilator/tracheotomy patients, the number of post-intensive care days in the

general acute care hospital drop significantly if the patient is discharged to an LTCH – 42 percent and 77 percent, respectively. From these analyses, CMS concludes that for cases with a length of stay equal to or less than the comparable general acute hospital stay, a full LTCH payment is inappropriate. The RTI included this proposal in its report to CMS last year.

LTCH patient severity and costs are very different from general acute care patients and validate the need for a separate LTCH payment. Concerns about early discharge from the general acute setting and "double" payment for LTCH cases are already addressed by use of the post-acute care transfer provision that reduces the PPS payment to general acute hospitals that discharge patients to an LTCH. The current short-stay outlier policy significantly reduces payments to LTCHs. Additional changes to further cut LTCH payment are unnecessary. **We urge CMS to omit its proposed short-stay outlier policy from the final rule.**

INFLATIONARY UPDATE AND BEHAVIORAL OFFSET FOR CODING CHANGES

For RY 2008, CMS forecasts a LTCH PPS market basket of 3.2 percent based on the rehabilitation, psychiatric and long-term care market basket. Unlike most Medicare payment systems, federal statute does not require CMS to annually apply a full market basket update to the LTCH PPS. In fact, CMS proposes to partially offset the 3.2 percent market basket update with a coding adjustment of negative 2.49 percent, intended to account for coding increases in FY 2005.

For 2005, CMS calculated a *total* case mix index increase of 3.49 percent, which the agency believes is partially due to coding behavior, called "*apparent* case mix," and partially due to the increased cost of treating more resource intensive patients, called "*real* case mix." CMS based its projected growth in real case mix of 1.0 percent on experience and patterns in the general acute inpatient PPS. Therefore, for RY 2008, CMS is recommending a coding adjustment of negative 2.49 percent that reflects CMS' estimates of *total* case mix index increase minus *real* case mix index increase in FY 2005 (3.49 – 1.0 = 2.49). With the agency's proposed negative 2.49 percent coding adjustment, the actual RY 2008 update would be only 0.71 percent.

CMS should use the full market basket index projection for updating LTCH payments – the 2.49 percent downward adjustment is unwarranted. CMS' policies over the last two years have reduced LTCH payments by more than 7 percent. With hospital input costs increasing significantly due to inflation, a full market basket update is warranted.

BUDGET-NEUTRAL RE-WEIGHTING OF THE LTCH DRGS

As the sole exception under Medicare, the LTCH DRGs may be re-weighted in a non-budget-neutral manner – a method that CMS utilized in RY 2007 to reduce Medicare payments to LTCHs. LTCH DRG re-weighting coincides with the annual re-weighting of the DRGs for general acute care hospitals, and takes effect each October 1. It captures changes in the relative cost of treating patients in each of the 538 LTCH DRGs, such as treatment patterns, technology

and number of discharges per DRG. In the proposed rule, CMS recommends that the annual re-weighting of the LTCH DRG be conducted on a budget-neutral basis, beginning October 1, 2007. This provision would be included in the FY 2008 proposed and final rules for the inpatient PPS. The agency is proposing this change since analysis of claims from FYs 2003 through 2005 indicates that LTCH coding practices have stabilized, and therefore, the most recent case mix increases are primarily due to higher patient severity rather than coding behavior, which had been identified as the primary cause in prior years. **The AHA supports re-weighting the LTCH DRGs in a budget-neutral manner and urges CMS to move forward with this proposal.**

If you have any questions, please feel free to contact me or Don May, vice president for policy, at (202) 626-2356 or dmay@aha.org.

Sincerely,

Rick Pollack
Executive Vice President

Submitter : Mr. Rick Pollack **Date:** 03/26/2007

Organization : American Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1529-P-78-Attach-1.DOC

#78

American Hospital Association

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March 26, 2007

Leslie Norwalk
Acting Administrator
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Hubert H. Humphrey Building
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Washington, DC 20201

RE: (CMS–1529–P) Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes; Proposed Rule, (Vo. 72, No. 21), February 1, 2007

Dear Ms. Norwalk:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed changes to its direct graduate medical education (DGME) and indirect medical education (IME) payment policies.

CMS proposes changes relating to Medicare reimbursement for time residents spend working in non-hospital settings, such as physician offices and clinics. Currently, in order for hospitals to receive payments for residents who rotate through non-hospital settings, hospitals must incur "all or substantially all" of the non-hospital site's costs associated with the residents. The proposed rule is intended to reduce the burden on hospitals by allowing the use of proxy data and lowering the cost threshold that must be incurred in order to demonstrate compliance with the "all or substantially all" requirement.

Specifically, CMS proposes to:

- Allow hospitals to assume that three hours of the physicians' time were spent supervising residents each week or to continue collecting actual data;
- Allow hospitals the choice of using national salary data to estimate teaching physicians' costs by specialty or to continue collecting actual data; and

AMERICAN HOSPITAL ASSOCIATION FOUNDED 1898

- Create a minimum threshold whereby hospitals must incur at least 90 percent of the sum of residents' salaries, fringe benefits, the portion of the cost of teaching physicians' salaries and fringe benefits attributable to supervision.

PAYMENT FOR DIRECT MEDICAL EDUCATION

The AHA appreciates CMS' effort to reduce the burden currently imposed on hospitals to demonstrate that they have incurred the required costs; however, we still fundamentally disagree with CMS' underlying policy. In April 2005, CMS released a set of "Q&As" explaining that hospitals must pay physicians who train residents in non-hospital settings to compensate them for incurred supervisory costs, even when physicians *volunteer* their time. CMS stated that, "where there is a cost to the non-hospital setting for training residents, we believe that the Medicare program is obligated to ensure that the non-hospital settings receive the funding they are entitled to receive from hospitals under the statute." The government does not customarily intervene in private contracts elsewhere in the Medicare program, nor does it establish such detailed policy when overall program spending is not affected. We are concerned that the proposed extensive requirements are going to influence inappropriately the way in which medical education is conducted. **We urge CMS to rescind the requirement that hospitals reimburse physicians who wish to volunteer their time.**

Three Hour Proxy. CMS proposes to allow hospitals to use three hours per week as a presumptive standard that a teaching physician spends performing non-patient care DGME activities at a non-hospital site. To determine the percentage of the average salary associated with the three hours a teaching physician is presumed to spend in non-patient care DGME activities, a hospital would divide three hours by the number of hours the non-hospital site is open each week. The hospital would then multiply this percentage of time spent in non-patient care DGME activities by the national average salary of the teaching physician's specialty to calculate the cost of the teaching physician's DGME time.

We question whether this will reduce burden, as it will be difficult for hospitals to implement. Resident rotations are rarely devoted to one non-hospital setting for a month or longer. More often, the rotations consist of partial days or partial weeks over a period of time at a non-hospital setting. Residents may even have three or four clinics that they are regularly visiting each week. For example, continuity clinics, which are required for internal medicine residents, are one half-day a week over three years. If hospitals were to assume three hours of supervisory costs per week per clinic, the estimate would be severely inflated. Thus, hospitals would have no choice but to collect specific information on each clinic, which is unduly burdensome given that smaller programs often contract with 50 non-hospitals sites and large programs can contract with hundreds. **Instead, we recommend that CMS allow physicians at non-hospital sites to sign attestation forms estimating their average time spent supervising residents per week.**

Salary Proxies. CMS proposes allowing hospitals to use physician compensation survey data as a proxy to determine the teaching physician costs associated with DGME in a program at a non-hospital site, although the hospital could continue to collect the actual data if it chooses. In

particular, CMS asks for comments on whether it should select the American Medical Group Association's annual *Medical Group Compensation and Financial Survey* to determine the cost of teaching physicians' time attributable to DGME or another physician compensation survey.

We suggest that CMS consider using reasonable cost equivalents (RCE), which are calculated from CMS' data, available to the public and are a stable source of salary proxies. If CMS decides against using RCEs, we would recommend using the Association of American Medical College's (AAMC) Faculty Roster Survey salary data, which is collected annually. The AAMC has an excellent response rate and can make its data publicly available. Although the AAMC's data set is external to CMS, it is well-known and stable.

Cost Threshold. CMS proposes revising the current definition of "all or substantially all of the costs" to require hospitals to incur at least 90 percent of the total costs of residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and benefits attributable to DGME.

The AHA believes 90 percent is higher than "substantially all" suggests. **CMS should reduce this threshold to 75 percent as there is precedent for such a level in other areas of the program and there are no implications for Medicare spending.**

If you have any questions, please feel free to contact me or Danielle Lloyd, senior associate director for policy, at (202) 626-2340 or dlloyd@aha.org.

Sincerely,

Rick Pollack
Executive Vice President

Submitter : **Ms. Kira Carter** **Date: 03/26/2007**

Organization : **Sparrow Specialty Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Other Proposed Policy Changes For The 2008 LTCh PPS Rate

Other Proposed Policy Changes For The 2008 LTCh PPS Rate

See Attachment

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

See Attachment

CMS-1529-P-79-Attach-1.DOC

#79

March 23, 2007

The Honorable Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C. 20201

Re: Comments on Medicare Program; 2008 Proposed Update Rule Published at 72 Federal Register 4776 *et seq.*

Dear Ms. Norwalk:

Sparrow Specialty Hospital (SSH) opened its doors May 2004 and received LTCH certification January 2005. SSH is an affiliate of Sparrow Health System and is located at 1210 W. Saginaw in Lansing, Michigan. We serve a significant percentage of Medicare patients residing in the Greater Lansing Area. As a Long Term Acute Care Hospital, Sparrow Specialty Hospital welcomes the opportunity to submit comments to the Centers for Medicare & Medicaid Services regarding the Medicare proposed rule published on February 1, 2007. This rule proposes significant changes to the admission practices of long-term acute care hospitals (LTCHs) as well as payment policies that would financially devastate our facility.

The 2008 Proposed rule update proposes significant changes to the LTCH industry in particularly as a LTCH provider I am troubled by the proposed expansion of the 25% rule. CMS justifies expansion of the 25% rule to all LTCHs, including grandfathered co-located LTCHs and freestanding LTCHs, based on the presumption that the Acute Care Hospital (ACH) patient discharged to the LTCH presumably is a "premature discharge" if the patient has not reached cost outlier status at the ACH. RTI, CMS' own contractor investigating these issues, has concluded that it cannot state that LTCHs are substituting for services already paid to IPPS hospitals. Without such evidence the proposal should be withdrawn.

In fact, there has been significant clinical and financial support presented by the National Association of Long Term Acute Care Hospitals (NALTH) that ACH patients are discharged based upon the expertise of the ACH physician, who has determined that it is appropriate for the patient to receive the specialized services of the LTCH in order to maximize the patient's recovery. In addition, most

admitting LTCHs or ACHs have no accurate method of determining if the ACH patient has reached outlier status. Those that do have such technology can only do so after the fact.

The proposal to expand the 25% rule fails to recognize the many localities nationwide in which LTCHs serve a small number of independent ACHs, thereby making it impossible for them to satisfy the 25% rule despite no control or ability to direct or influence admission patterns. Sparrow Specialty Hospital is located in a two-hospital town, the proposed expansion of the 25% rule would unfairly disadvantage SSH from providing the needed LTCH services for residents in the greater Lansing Area (approximately 400,000 residents). The largest acute care hospital provider in the area is Sparrow Hospital, which accounts for 60% of Medicare admissions in their designated Metropolitan Statistical Area (MSA). The other acute care hospital provider in the area, Ingham Regional Medical Center, accounts for 40% of Medicare admissions. The referral pattern of admissions to SSH from each of these hospitals directly correlates with the overall percentage of the Medicare market share between the two Lansing based hospitals.

I understand the concern as expressed in the RTI study regarding growth and abuse in the LTCH industry. As a Michigan based LTCH provider, I can tell you that I have not seen this behavior. Michigan is a Certificate of Need State so the number of LTCH beds is determined and approved by the State, in addition Michigan LTCHs are mandated by the CMS Fiscal Intermediary for our Region to utilize the LTCH InterQual Criteria for admission purposes. LTCH admission data (by facility) is reviewed annually by the Michigan Peer Review Organization (MPRO), which is the Quality Improvement Organization (QIO) for Michigan, to ensure medical necessity of hospital services provided to Medicare beneficiaries based on the InterQual criteria.

Recommendations:
As a LTCH provider, I urge CMS to eliminate any expansion of the 25% rule, which would limit payment for care most appropriate based on the patient's medical condition and needs:

1. **Based on the recommendation of the RTI study, I would suggest the CMS institute a program to review admissions and deny payment for services that do not meet criteria. I would recommend that no further changes be put in place in the LTCH industry until a universal admission criteria is developed and instituted.**
2. **In efforts to limit the growth in the industry, I would recommend a moratorium be put in place and recommendations developed on how LTCH services can be added in communities that are currently underserved.**
3. **In addition, based on the oversight and compliance of Michigan LTCHs, a more prudent approach for CMS to take in the event that the 25% rule is expanded would be the implementation of exemptions for hospitals that are governed under programs such as certificate of need and are governed by their Fiscal Intermediary to use an admission criteria such as InterQual. Michigan tightly regulates its LTCH patient population, but does not compromise patient needs. This is an example of how hospital certification criteria coupled with LTCH patient admission criteria can be used to regulate the LTCH industry.**

We appreciate your attention to the important issues related to LTCH hospitals raised in this letter. Ensuring access to these facilities for those who truly need it is vitally important, and I urge you to work towards development of a more targeted approach to get the right type of patient into LTCH hospitals.

Sincerely,

Kira M. Carter, MHA, FACHE
President and CEO
Sparrow Specialty Hospital

Submitter : **Mr. Joseph Parker** **Date: 03/26/2007**

Organization : **Georgia Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Background

Background

See Attached Letter

GENERAL

GENERAL

See Attachment

Impact

Impact

See Attached Letter

LTC-DRG Classifications and Relative Weights

LTC-DRG Classifications and Relative Weights

See Attached Letter

Other Proposed Policy Changes For The 2008 LTCh PPS Rate

Other Proposed Policy Changes For The 2008 LTCh PPS Rate

See Attached Letter

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

None Here

CMS-1529-P-80-Attach-1.DOC

#80

March 26, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: (CMS–1529–P) Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes, (Vol. 72, No. 21), February 1, 2007

Dear Ms. Norwalk:

The Georgia Hospital Association, on behalf of its 172 member hospitals and health systems, appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed changes to the long-term care hospital (LTCH) prospective payment system (PPS). We disagree with the CMS proposed expansion of the 25% Rule on patient referral source, changes to the short-stay outlier policy and an offset for coding changes. We support the move to re-weight the LTCH diagnosis-related groups (DRGs) in a budget-neutral manner.

EXPANSION OF THE 25% RULE TO FREESTANDING AND GRANDFATHERED LTCHS
In its fiscal year (FY) 2005 rule, CMS implemented payment limitations for LTCHs that are co-located with other hospitals in response to concerns about "inappropriate patient shifting" between acute care hospitals and LTCHs. Under the rule, when an LTCH is co-located with another hospital, no more that 25 percent of the LTCH's admissions from the co-located hospital will be paid at the full LTCH prospective payment rate. If the LTCH receives more than 25 percent of its admissions from the co-located hospital, the LTCH payments will be reduced for those patients exceeding the limit. CMS adopted the 25% Rule, in part, to address its concern that locating an LTCH within an acute care hospital might encourage the shifting of patients from host hospitals to co-located LTCHs for financial – rather than medically appropriate – reasons

As part of its annual LTCH PPS payment update for 2008, CMS proposes to extend the 25% Rule to all LTCHs, including freestanding and satellite facilities, as well as LTCHs that were exempted from the original 25% Rule. To accommodate LTCHs located in rural areas or in metropolitan statistical areas (MSAs) served by one or more "MSA dominant hospitals" (i.e., hospitals that generate more than 25 percent of the Medicare discharges in the MSA), the agency increases the referral limitation to 50 percent. However, this move falls short of addressing the unique needs of most LTCHs and the general acute care hospitals that rely on them as part of their community's health care continuum.

As with the existing 25% Rule application, CMS' proposed expansion to all LTCHs lacks any meaningful relationship to the clinical appropriateness of LTCH admissions. LTCHs provide intense care to patients who require longer lengths of stay than a typical patient in an inpatient hospital, such as those on ventilators or burn victims. Any proposed policy regarding LTCHs should ensure access for patients for

whom LTCH care is medically appropriate– a view supported by the Medicare Payment Advisory Commission. CMS is making payment decisions based on an arbitrary percentage. Last year, CMS released a report by the Research Triangle Institute (RTI) that identified feasible patient and facility criteria that would help distinguish LTCHs from other acute care facilities. However, CMS has not yet used the report to produce specific policy recommendations.

Rather than limiting access to LTCH services through payment cuts, we urge CMS not to move forward with the proposed rule, but to work with the RTI and LTCH providers to develop appropriate facility and patient-centered criteria to determine the types of patients that should be treated in LTCHs.

SHORT-STAY OUTLIERS

The LTCH short-stay outlier policy applies to cases with a length of stay up to 5/6 of the geometric mean length of stay for a particular diagnosis. In rate year (RY) 2007, CMS modified the LTCH short-stay outlier policy by adding the fourth payment alternative described below; as a result, Medicare payments to LTCHs were reduced by an estimated $156 million. Currently, short-stay outlier cases are paid the lesser of four payment alternatives:

- 100 percent of patient costs;
- 120 percent of the per diem of the LTCH DRG payment;
- the full LTCH DRG payment; or
- a blend of the general hospital inpatient PPS per diem and 120 percent of the LTCH PPS per diem. As a patient's length of stay increases, the LTCH DRG portion of the blend increases.

CMS' analysis of FY 2005 MedPAR data shows that 42 percent of LTCH short-stay outlier cases had lengths of stay that were less than or equal to the comparable length of stay (plus one standard deviation) for general acute care hospitals. Further data analysis shows that for ventilator and ventilator/tracheotomy patients, the number of post-intensive care days in the general acute care hospital drop significantly if the patient is discharged to an LTCH – 42 percent and 77 percent, respectively. From these analyses, CMS concludes that for cases with a length of stay equal to or less than the comparable general acute hospital stay, a full LTCH payment is inappropriate. The RTI included this proposal in its report to CMS last year.

LTCH patient severity and costs are very different from general acute care patients and validate the need for a separate LTCH payment. Concerns about early discharge from the general acute setting and "double" payment for LTCH cases are already addressed by use of the post-acute care transfer provision that reduces the PPS payment to general acute hospitals that discharge patients to an LTCH. The current short-stay outlier policy significantly reduces payments to LTCHs. Additional changes to further cut LTCH payment are unnecessary. **We urge CMS to omit its proposed short-stay outlier policy from the final rule.**

INFLATIONARY UPDATE AND BEHAVIORAL OFFSET FOR CODING CHANGES

For RY 2008, CMS forecasts a LTCH PPS market basket of 3.2 percent based on the rehabilitation, psychiatric and long-term care market basket. Unlike most Medicare payment systems, federal statute does not require CMS to annually apply a full market basket update to the LTCH PPS. In fact, CMS

proposes to partially offset the 3.2 percent market basket update with a coding adjustment of negative 2.49 percent, intended to account for coding increases in FY 2005.

For 2005, CMS calculated a *total* case mix index increase of 3.49 percent, which the agency believes is partially due to coding behavior, called "*apparent* case mix," and partially due to the increased cost of treating more resource intensive patients, called "*real* case mix." CMS based its projected growth in real case mix of 1.0 percent on experience and patterns in the general acute inpatient PPS. Therefore, for RY 2008, CMS is recommending a coding adjustment of negative 2.49 percent that reflects CMS' estimates of *total* case mix index increase minus *real* case mix index increase in FY 2005 (3.49 – 1.0 = 2.49). With the agency's proposed negative 2.49 percent coding adjustment, the actual RY 2008 update would be only 0.71 percent.

CMS should use the full market basket index projection for updating LTCH payments – the 2.49 percent downward adjustment is unwarranted. CMS' policies over the last two years have reduced LTCH payments by more than 7 percent. With hospital input costs increasing significantly due to inflation, a full market basket update is warranted.

BUDGET-NEUTRAL RE-WEIGHTING OF THE LTCH DRGS

As the sole exception under Medicare, the LTCH DRGs may be re-weighted in a non-budget-neutral manner – a method that CMS utilized in RY 2007 to reduce Medicare payments to LTCHs. LTCH DRG re-weighting coincides with the annual re-weighting of the DRGs for general acute care hospitals, and takes effect each October 1. It captures changes in the relative cost of treating patients in each of the 538 LTCH DRGs, such as treatment patterns, technology and number of discharges per DRG. In the proposed rule, CMS recommends that the annual re-weighting of the LTCH DRG be conducted on a budget-neutral basis, beginning October 1, 2007. This provision would be included in the FY 2008 proposed and final rules for the inpatient PPS. The agency is proposing this change since analysis of claims from FYs 2003 through 2005 indicates that LTCH coding practices have stabilized, and therefore, the most recent case mix increases are primarily due to higher patient severity rather than coding behavior, which had been identified as the primary cause in prior years. **The GHA supports re-weighting the LTCH DRGs in a budget-neutral manner and urges CMS to move forward with this proposal.**

Sincerely,

Joseph A. Parker
President

Submitter : **Mr. Edward Kalman** **Date: 03/26/2007**

Organization : **National Association of Long Term Hospitals**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

Re-submission of the National Association of Long Term Hospital's complete comment letter.

Submitter : Ms. Alan Lyons **Date:** 03/26/2007

Organization : Ms. Alan Lyons

Category : Individual

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

Why isn't paying 100% of the Intern or Resident's salary enough to cover "substantially all of the cost". If the hospital that pays the salary for this off-site office rotation cannot claim this resident then no one can. Shouldn't 100% of a resident's time be accounted for and allowed to be claimed by a provider?

Submitter : Mrs. Cheryl Burzynski **Date:** 03/26/2007

Organization : Bay Special Care Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1529-P-83-Attach-1.DOC

#83

March 14, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1529-P
P.O. Box 8015
Baltimore, Maryland 21244-8015

Re: Comments on Medicare Program; 2008 Proposed Update Rule
Published at 72 Federal Register 4776 *et seq.*

Dear Ms. Norwalk:

Bay Special Care Hospital (BSCH) submits these comments on proposed rules published on February 1, 2007 at 72 *Fed. Reg.* 4776 et seq. This rulemaking seeks to make significant changes to the admission practices of long-term care hospitals (LTCHs) as well as payment policies.

Bay Special Care Hospital was established on June 30, 1994 and is located at 3250 E. Midland Road, Bay City, MI 48706. Its location is approximately five miles from its host hospital, Bay Regional Medical Center (BRMC), which is located at 1900 Columbus Avenue, Bay City, MI 48708. BSCH has been deemed a Hospital within a Hospital (HwH) by CMS due to an inpatient rehabilitation unit owned and operated by BRMC being located within the same West Campus facility. BSCH was granted grandfathered status by the BBA of 1997, a status which we feel we should maintain to be excluded from the proposed expansion of the 25% rule. The proposal to expand the 25% rule to grandfathered hospitals violates the statutory protection given to our hospital by Congress in recognition of our unique status.

Our hospital serves an average of 295 patients per year, and a significant percentage of Medicare patients reside in Bay County, Saginaw, Midland and surrounding counties. We are located in a small city of approximately 40,000 residents and have only one acute care hospital in our community. Outlying cities and their hospital systems are located approximately 15-20 miles or more away from our city and location. To shift patients outside of one community to another is not customary as physicians prefer to provide care through the entire episode of care/continuum. In our location, it would be nearly impossible to obtain 75% of our Medicare patients from a source other than the only hospital located in our community. We have outcomes that we are proud of and have successfully discharged 48% of our Medicare patients to their homes over the past three fiscal years. These discharge outcomes are similar to prior years. We feel that these, as well as other quality initiatives, demonstrate a successful outcome for our patients who have multiple co-morbid conditions requiring extended hospital level care.

CMS' proposed expansion of the 25% rule to freestanding and grandfathered hospitals, and its "consideration" of a policy to expand the short stay outlier ("SSO") payment policy to allow "extreme" SSO cases to be paid comparable to IPPS cases, both are unfair and unsupported by facts, and contrary to the clinical and financial data available. The two proposals would drastically reduce payments to Bay Special Care Hospital in fiscal year 2008 by approximately 47% percent, forcing BSCH to operate at a significant loss when treating Medicare patients. BSCH urges CMS to not adopt the proposed expansion of the 25% rule and to reject its consideration of the extreme SSO policy because the continued operation of BSCH and the patients it serves will be placed in jeopardy if they are adopted.

In the preamble to the update rule CMS repeatedly justifies both of its proposals by making the generalized, unsupported, and incorrect statements that in the situations the proposals are intended to address the LTCH is behaving like a ACH, or that the LTCH is acting like a step-down unit for a ACH, or that the patient presumably was discharged by the ACH to the LTCH during the same episode of care and the LTCH is not providing complete treatment. CMS points to the statutory difference between LTCHs and ACHs that was intended to pay LTCHs

based upon "the different resource use" of LTCHs as compared to ACHs. In fact, LTCHs do provide different services to patients, and patients in LTCHS do utilize different resources than ACHs, making it inappropriate to pay LTCH discharges under the IPPS, and CMS has presented no data to the contrary to support its proposals other than presumptions and beliefs. CMS' own contractor, RTI, noted in the Executive Summary to its report that "[u]nderstanding whether LTCH hospitals are substituting for services already paid to IPPS hospitals or whether LTCHs are providing specialized services is not well understood." 72 Fed. Reg. 4885.

As described in greater detail in the comments submitted by NALTH, physicians at ACHs use their expertise and experience to discharge certain patients to LTCHs because the specialized care they can receive at the LTCH is very different than the services provided at an ACH, and such care, and the timing of such care, clearly are in the best interests of the patient's medical care. In general, ACHs are "diagnosis focused" and provide critical care to acutely ill patients by focusing on a single clinical dimension, whereas the LTCH is designed to provide the complete array of team-based services that can focus on the recovery of the whole patient. LTCHs often help patients recover all functions (both cognitive and physical) and return to the community. ACHs simply are not designed to provide these services, and there is no current incentive for them to expend the significant resources to try to replicate those specialized services that already exist in LTCHs. The physicians at the ACH also make the medical determination of when the patient is appropriate to be transferred from the ACH to a LTCH based upon the patient's condition, medical needs, and availability of appropriate services. It makes little sense for a patient to remain at an ACH instead of being transferred to a LTCH, and thus delay (or eliminate entirely) the commencement of needed specialty services, purely for payment system reasons.

Despite CMS's generalized statements to the contrary, Lewin has demonstrated that SSO patients in a LTCH cost far more than patients with the same DRG in an ACH, and their length of stay in a LTCH more than double of those with the same DRG in an ACH. There simply is no support for CMS' belief or presumption that patients in LTCHs should be paid like patients in an ACH.

Expanded 25% rule

CMS justifies expansion of the 25% rule to all LTCHs, including grandfathered co-located LTCHs and freestanding LTCHs, based on the presumption that the ACH's discharge to the LTCH presumably is a "premature discharge" if the patient has not reached cost outlier status at the ACH. As noted above, there is no clinical or financial evidence to support CMS' conclusion that the patient is discharged prematurely. RTI, CMS' own contractor investigating these issues, has concluded that it cannot state that LTCHs are substituting for services already paid to IPPS hospitals. Without such evidence the proposal should be withdrawn. In fact, there is significant clinical and financial support presented by NALTH that ACH patients are discharged based upon the expertise of the ACH physician, who has determined that it is appropriate for the patient to receive the specialized services of the LTCH at that time in order to maximize the patient's recovery.

The proposal to expand the 25% rule fails to recognize the many localities in which LTCHs serve a small number of independent ACHs, thereby making it impossible for them to satisfy the 25% rule despite no control or ability to direct or influence the admission patterns.

Bay Special Care Hospital questions the basis of the 25% threshold itself. CMS has presented no evidence to show that there is any statistical basis for applying such an arbitrary number throughout the country to penalize LTCHs.

Expanding the 25% rule to all LTCHs not only will jeopardize patients' access to appropriate medical care, but the significant and inappropriate financial losses it will generate will all but guarantee the closure of a significant number of LTCHs, thereby preventing access to these unique services by many Medicare beneficiaries.

Bay Special Care Hospital urges CMS not to adopt the proposed rule as published. The approximately 15 LTACs with grandfathered status were all established in good faith prior to growth in the industry. The continued operation of BSCH and the patients it serves will be placed in serious jeopardy if the proposed rules are adopted. Adoption of the expanded 25% rule could indeed cause the closure of this facility as well as many others, cause a

loss of LTAC level of care in our community, and jeopardize over 100 immediate jobs within BSCH and numerous others in the community.

Extreme SSO policy

As noted above, the extreme SSO policy CMS is considering is contrary to clinical and financial realities. Under the current SSO policy a LTCH will at best receive only its cost for a SSO; there is no incentive for a LTCH to admit a patient who is likely to become a SSO. Under the extreme SSO policy being considered, a LTCH would undoubtedly lose a significant sum on treating the patient.

Besides not having any financial incentive to admit an extreme SSO, CMS also assumes that LTCHs are able to predict, prior to admission, which patients will become SSOs, much less extreme 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. 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 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.

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

In view of the foregoing:

- Bay Special Care Hospital respectfully requests that CMS not expand the 25% rule to freestanding and grandfathered hospitals and that it reject the extreme SSO policy under consideration.

- We support a six-month extension for comments and to allow the national trade organizations an opportunity to collaborate for the good of the industry.

- We support a LTAC moratorium until 2010. The Lewin Group has provided a study of savings that the limited moratorium would provide and we encourage CMS to review that information provided by NALTH.

- We support implementation of a universal admission, continued stay and discharge criteria for LTACs whether it be NALTH criteria, InterQual or another validated LTAC tool.

- We support increased QIO review of LTACs throughout the United States.

I am grateful for this opportunity to express my opinions and hope that you will take them into consideration prior to the final ruling. Thank you.

Sincerely,

Cheryl A. Burzynski, President

Submitter : Mr. John Ryder **Date:** 03/26/2007

Organization : Borgess-Pipp Hospital

Category : Hospital

Issue Areas/Comments

Background

Background

Borgess-Pipp Hospital submits these comments on proposed rules published on February 1, 2007 at 72 Fed. Reg. 4776 et seq. This rulemaking seeks to make significant changes to the admission practices of long-term care hospitals (LTCHs) as well as payment policies.

Borgess-Pipp Hospital was established as an LTCH on July 1st, 2003 and is located at 411 Naomi St., Plainwell, Michigan, 49080. Prior to being designated as an LTCH, the hospital served as a small community acute care hospital. The facility has continuously served the Plainwell-Otsego community and surrounding area for over forty years. As an LTCH, it serves a significant percentage of Medicare patients residing in Allegan County and the greater Kalamazoo area. The hospitals LTCH designation helps maintain its viability to provide a range of other services to the community. These include a Rural Health Clinic, Emergency Room, Ambulance Service and a range of outpatient diagnostic services. Borgess-Pipp Hospital is a not-for-profit hospital.

CMS' proposed expansion of the 25% rule to freestanding and grandfathered hospitals, and its consideration of a policy to expand the short stay outlier (SSO) payment policy to allow extremely SSO cases to be paid comparable to IPPS cases, both are unfair and unsupported by facts, and contrary to the clinical and financial data available. The two proposals would drastically reduce payments to Borgess-Pipp Hospital in fiscal year 2008. Preliminary estimates are that these rule changes will reduce payments to the hospital by approximately $2M or 20%-25% percent of LTCH payments, forcing the Hospital to operate at an unsustainable loss when treating Medicare patients. Borgess-Pipp Hospital urges CMS to not adopt the proposed expansion of the 25% rule and to reject its consideration of the extremely SSO policy because the continued operation of Borgess-Pipp Hospital and the patients and community it serves will be placed in jeopardy if they are adopted.

Other Proposed Policy Changes For The 2008 LTCh PPS Rate

Other Proposed Policy Changes For The 2008 LTCh PPS Rate

Expanded 25% rule

CMS justifies expansion of the 25% rule to all LTCHs, including grandfathered co-located LTCHs and freestanding LTCHs, based on the presumption that the ACH s discharge to the LTCH presumably is a premature discharge if the patient has not reached cost outlier status at the ACH. As noted above, there is no clinical or financial evidence to support CMS conclusion that the patient is discharged prematurely. RTI, CMS own contractor investigating these issues, has concluded that it cannot state that LTCHs are substituting for services already paid to IPPS hospitals. Without such evidence the proposal should be withdrawn. In fact, there is significant clinical and financial support presented by NALTH that ACH patients are discharged based upon the expertise of the ACH physician, who has determined that it is appropriate for the patient to receive the specialized services of the LTCH at that time in order to maximize the patient s recovery.

The proposal to expand the 25% rule fails to recognize the many localities in which LTCHs serve a small number of independent ACHs, thereby making it impossible for them to satisfy the 25% rule despite no control or ability to direct or influence the admission patterns.

Borgess-Pipp Hospital questions the basis of the 25% threshold itself. CMS has presented no evidence to show that there is any statistical basis for applying such an arbitrary number throughout the country to penalize LTCHs.

Extreme SSO policy

As noted above, the extreme SSO policy CMS is considering is contrary to clinical and financial realities. Under the current SSO policy a LTCH will at best receive only its cost for a SSO; there is no incentive for a LTCH to admit a patient who is likely to become a SSO. Under the extreme SSO policy being considered a LTCH would undoubtedly lose a significant sum on treating the patient.

Besides not having any financial incentive to admit an extreme SSO, CMS also assumes that LTCHs are able to predict, prior to admission, which patients will become SSOs, much less extreme 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.

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.

Proposed Changes TO LTCH PPS

Payment Rates For The 2007 LTCh PPS Rate Year

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

We believe the impact of rules changes is being significantly underestimated by CMS. In Michigan alone one third to one half of LTCHs could be forced to close based on informal discussions we ve had with other Michigan LTCHs. This has serious implications for the patients that would otherwise receive care in these LTCHs. The short term acute care hospitals that rely on these LTCHs will experience serious disruption of their ability to provide care including frequent shortages of critical care resources (beds and staff) that will be tied up caring for patients that would be much more appropriately placed in LTCHs.

Expanding the 25% rule to all LTCHs not only will jeopardize patients access to appropriate medical care, but the significant and inappropriate financial losses it will generate will all but guarantee the closure of a significant number of LTCHs, thereby preventing access to these unique services by many Medicare beneficiaries.

Submitter : Ms. Helen Savitzky **Date:** 03/26/2007

Organization : Memorial Hermann

Category : Hospital

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

The Provider appreciates the attempt by CMS to clarify the regulations related to the non hospital site training, and the meaning of "all or substantially all" of the cost involved in the resident training. The Provider believes that the proposed methodology is quite complex, and will be extremly burdensome for the Provider to calculate the appropriate dollar amounts to add to the non hospital site contracts.

The Provider's non hospital sites train multiple residents for short periods of time (under one week) with multiple PGYs. It would be extremely difficult to determine the actual cost of the residents' stipend and benefits for each of the non hospital sites. The resident rotation spent in the clinic averages two days per week.

The hospital is over its 1996 cap for both IME and GME. This new methodology will require a great deal of work and time to create the data required for the contracts. What is the benefit in providing this data for the Provider?

Does the calculation of payment of "all or substantially all" of the cost of the resident stipend and benefits and the physician's supervisory costs need to be attached to the non hospital site contract? This will be difficult to do, as the Provider does not know the exact number of residents or their rotations before the school year is over. This contract must be submitted before the school year starts. In order to calculate the amounts in the contract, the Provider must use either prior year data (rotation schedules for prior school year, updated for any changes in stipend and benefits, if this allocation can be determined), and some other proxy for the physician salary. If there are changes in the actual data, should the contract be amended in some way? (Residents change their rotation schedules frequently, which would change the measurement of the time and cost).

In order to utilize a consistent salary basis for the physicians, the Provider believes that RCEs would be a reasonable alternative source of physician salary data. The Provider believes that if this standard is appropriate for an estimate of the physician salaries on the cost report, it should be an adequate measure of the salaries for this purpose as well.

Finally, the Provider notes that the physicians associated with the medical school with which it is affiliated volunteer their teaching time both in the hospital as well as at the non hospital sites. The Provider believes that its contract with the medical school delineates the time spent by the physicians, and if the time is considered to be donated, this should be acceptable. The Provider further notes that these physicians are employed by the medical school, so the "group practice" is owned by the medical school, with the anticipation that teaching will occur in the clinics. This is a cost of the clinic as a function of the medical school, and not a portion of the physicians' time that could be spent on other activities.

The Provider appreciates the time and effort of CMS personnel, and appreciates the opportunity to comment on this proposed rule.

Submitter : Mr. Cecil Terry **Date:** 03/26/2007

Organization : BJC HealthCare

Category : Hospital

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION

These comments are being submitted on behalf of our system s two teaching hospitals, Barnes-Jewish Hospital and St. Louis Children s Hospital. First we appreciate the reduction in the substantially all cost threshold to 90% but suggest that this should be further reduced considering the fact that the vast majority of non-hospital site teaching involves residents seeing patients along with teaching physicians when they are performing billable patient services. Under the CMS definition of, almost all of the nonpatient care teaching activities are confined to very brief discussions with residents after seeing specific patients and in completing resident evaluations.

To simplify the number of data sources that teaching hospitals and contractors must access to apply provisions of the proposed rule, we suggest that the Medicare reasonable compensation equivalents (RCEs) be used as the source of the National Physician Salary Data.

We appreciate the options for computing the physician supervision cost using the National Physician Salary Data and the presumption of 3 hours per week, per off site location for nonpatient care direct GME activities and the computation examples. However, these computations and obtaining the documentation to perform them are not nearly as simple as appears to be presumed in the preamble to the proposed rule. We do not believe that CMS is fully aware of the onerous administrative challenge this creates, especially for large teaching hospitals with global agreements with Medical Schools, with lump sum payments to the Schools that cover all DGME teaching activities.

At a minimum, we urge CMS to simplify the substantially all cost documentation requirements for nonhospital site Medical School clinics where hospitals have global agreements with the Medical Schools that require lump sum payments to the Medical Schools for all DGME teaching costs regardless of location, i.e., in the hospital or in nonhospital Medical School clinics.

To provide some basis of understanding the enormity of the documentation task imposed by the proposed rule, following is a brief description of the Hospitals nonhospital site rotations. Each year the potential number of residents (not FTEs) involved in these rotations is over 200. The number of nonhospital sites is well over 100, with over half of these being to Medical School clinics (covered by the respective global agreements, with lump sum payments to the Medical School for all teaching activities). Other nonhospital site rotations are to private physician offices and group practice clinics, not directly operated by the Medical School.

These rotations are never a full year, as presented in some of the CMS examples, but are, instead, usually less than one week per month that can occur every month or only one time during the year. Many of the rotations provide very brief clinical experience of one half day, twice a month. However, the Hospitals will be required to collect documentation for this large number of brief rotations in order to claim reimbursement for this nonhospital site training time.

Global agreements with individual agreements for each Medical School clinic will be an enormous burden to produce and in many cases may be impossible to produce in advance of the rotations. For residents in advanced training (i.e., PGY-3s and 4s) it is common for these residents to be assigned to follow a teaching physician in a specialty. During the course of a typical day, the resident will be seeing patients with the teaching physician in both the Medical School clinics (physically adjacent to the hospital) and in hospital service areas, moving back and forth one or more times during the day. Thus, the amount of time the residents spend in the nonhospital sites will not be know until the rotations are over.

Thank you for considering these comments.

Submitter : Mr. Cecil Terry **Date:** 03/26/2007

Organization : BJC HealthCare

Category : Hospital

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

We do appreciate the relief provided to hospitals of not being required document nonhospital site training for the number of residents which are in excess of the hospitals current resident caps. We do request that CMS provide a means of reporting the number of residents in excess of the current caps for which current reimbursement is not being claimed for nonhospital site training in such a manner that these hospitals will not be penalized for these unreimbursed nonhospital site rotations if or when future aggregate resident cap amounts are increased based on current cost report data.

Thank you for your consideration of this comments to this proposed rule.

Submitter : Mr. Charles Clayton **Date:** 03/26/2007

Organization : Alliance for Academic Internal Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1529-P-88-Attach-1.DOC

#88

March 26, 2007

Leslie V. Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

File Code: CMS-1529-P
Re: Payment for Direct Graduate Medical Education

Dear Ms. Norwalk:

On behalf of the Association of Program Directors in Internal Medicine (APDIM)—the international organization of accredited internal medicine residency programs—thank you for the opportunity to submit comments on the proposed rule regarding direct graduate medical education payments, which was contained in the long-term care hospital proposed rule issued by the Centers for Medicare & Medicaid Services (CMS) January 25, 2007.

APDIM represents the leaders of the 385 internal medicine residency programs in the United States. These programs collectively train over 22,000 internal medicine residents each year; these residents represent over 21 percent of all physicians-in-training in programs accredited by the Accreditation Council for Graduate Medical Education.

Internal medicine residency programs are sponsored by a variety of institutions, including medical schools and their affiliated hospitals, not-for-profit and for-profit community teaching hospitals, municipal health systems, and Department of Veterans Administration medical centers. Depending on their structure, affiliations, and local medical environment, these residency programs train residents in a variety of non-hospital sites. Use of non-hospital sites ranges widely across programs. At one end of the range, residency programs may use non-hospital sites rarely, perhaps only for occasional training experiences to expose internists-in-training to fields such as ophthalmology, dermatology, and orthopedics, fields to which internal medicine residents must have exposure to meet accreditation requirements and become prepared for future practice. At the other end of the range, internal medicine residency programs use non-hospital sites extensively; such uses include having residents at these sites for several month-long rotations to learn and practice primary care delivery.

Unfortunately, CMS's current approach to the counting of resident time spent in non-hospital settings has resulted in significant confusion and concern, leading many programs to suspend or eliminate non-hospital rotations. In situations where such changes are not possible, internal medicine residencies and their sponsoring institutions have incurred a significant cost burden not only in paying non-hospital sites but also in engaging in efforts to comply with the regulations. These results directly counter the intent Congress expressed when it acted to allow counting of

resident time in these settings initially. As such, APDIM strongly encourages CMS to thoroughly reconsider its definition of the "all or substantially all" language in the statute and reinstate the agency's prior definition, which limited "all or substantially all" to residents' stipends and benefits as well as residents' travel and lodging costs.

Regardless of the above comment, APDIM believes CMS's proposed revisions will help address some of the sections of the present rule that have created the most confusion and compliance hardship for internal medicine residency programs and their sponsoring institutions. To further improve the proposal, APDIM strongly recommends the final rule reflect the comments below:

1. The association supports setting a threshold for "substantially all" of the costs of non-hospital training to a level below 100 percent and strongly recommends this threshold be 75 percent. The clarification of "substantially all" is vitally important. Previously, residency programs had no other choice than to use 100 percent as a marker for this definition. However, APDIM proposes CMS set a final threshold other than 90 percent. "Substantially all" can allude to different levels of cost. Given the congressional intent to support training in non-hospital settings, APDIM believes a threshold that will not continue to dissuade programs from using these settings is highly important. APDIM believes a threshold of 75 percent meets the definition of "substantially all" and lessens the barrier to moving training imposed by this rule to such an amount that will encourage rather than discourage non-hospital training.

2. The association strongly proposes CMS clearly explain how to prorate the calculations in the proposed rule. APDIM is very concerned that the proposed rule does not appear to address the need to prorate the physician supervisory costs to reflect the actual teaching commitment. As outlined above, internal medicine residencies employ the teaching services of non-hospital faculty for a number of educational rotations. In one hypothetical example, one teaching physician may supervise one resident for one four-hour session in a non-hospital office once per week. APDIM believes it is only sensible to prorate the entire payment calculation to reflect this 10 percent commitment to teaching.

   Unfortunately, it is APDIM's understanding that CMS does not presently propose to allow prorating below the weekly standard implied by using three hours per week as proxy for educational efforts. However, it is only through prorating all elements of the calculation that this proxy, and all proposed proxies, can be effectively used. For instance, in the example noted above, not allowing prorating below a weekly level would imply that the physician should be paid for three hours of non-billable educational effort in the four-hour session. Prorating the overall calculation to the percentage of time spent with residents (perhaps using the non-hospital site's opening hours as the denominator and the actual time spent with residents as the numerator) is the only means by which the logic of the proposed proxies can be extended.

3. The association supports allowing residency programs and sponsoring institutions to use national salary data for teaching physicians but strongly recommends CMS reconsider its approach regarding which data should be used. First, the association recommends using

the specialty of the resident being taught, not the specialty of the teaching physician, as the basis for determining which salary should be used in the cost calculations. Second, APDIM recommends CMS consider the approach used by the Department of Veterans Affairs in setting salaries for its physicians, notably by employing multiple surveys of physician compensation.

With regard to the first issue, APDIM acknowledges that a wide array of specialists teach residents in other specialty areas. Within the specialty of internal medicine, for example, *subspecialists* in internal medicine as cardiologists, gastroenterologists, and pulmonary and critical care medicine physicians all teach internal medicine residents. These subspecialists are board certified in both internal medicine and their subspecialty field. Another example of physician teachers of internists who have two certifications are family physicians who have subspecialized in geriatrics. Additionally, specialists in fields like ophthalmology and orthopedics also teach internal medicine residents.

Despite their differences in specialization, all of teachers have one characteristic in common—teaching future internists how to be internists. The cardiologist, for example, teaches the internal medicine resident what he or she needs to know about heart disease and the cardiovascular system as an internist, not a cardiologist. Similarly, the ophthalmologist and family physician-geriatrician teach about basic care of eye diseases and eye care referrals and caring for elderly patients, respectively, not what it takes to be a specialist in their field. Unfortunately, the proposed rule sets out a variety of confusing standards for determining the salaries that can be used for calculating costs of these teachers' time. For the cardiologist teaching internal medicine residents, the salary for general internists should be used. For an ophthalmologist, data on ophthalmologists' salaries should be used. And, it is not entirely apparent what salary should be used for the family physician-geriatrician, although the use of a general internists' salary can be reasonably assumed.

APDIM recommends CMS avoid this confusion by stating that, for core residency training, the specialty of the resident being trained should be the only determining factor in setting the salary for use in the proposed payment calculations. The association justifies this proposal in that its adoption should provide immediate clarity to the issue, lowering barriers to the use of non-hospital settings. The association also believes this recommendation can be justified in that residency training programs have the freedom to use many different specialists in the training of residents. For example, Internal Medicine Residency Program A may have ophthalmologists teach eye diseases, and Internal Medicine Residency Program B may have general internists teach eye diseases (such variability in teaching assignments may happen within the same residency as well). Adoption of the association's proposal will equilibrate the costs residencies and their sponsoring institutions for teaching of the same content regardless of the teachers' specialization.

On a related technical note, APDIM also asks CMS to clarify the issue of physician salary with regard to the current situation of time-limited certification. In internal medicine, as in other disciplines, certificates awarded by the specialty certifying boards

are now time-limited. (For internal medicine, all certificates awarded after 1990 have been time-limited.) In internal medicine, the American Board of Internal Medicine has decided that subspecialists in internal medicine (cardiologists, for example) may renew their certification in their subspecialty (cardiology, in this example) without recertifying their certification in the core specialty (internal medicine, in this example). To date, the majority of subspecialists with time-limited core specialty and subspecialty certification have chosen to allow their core specialty certificate to lapse and only recertify in their subspecialty. However, some subspecialists have chosen to recertify in both the core and subspecialty areas, and a small number of subspecialists have permanent certification in internal medicine but time-limited subspecialty certification. This situation has caused some havoc at the local level already, and using *current* certification status as a basis for determining physician salary proxies in CMS's final rule will likewise create many problems. Therefore, regardless of CMS's final disposition on the issue outlined in the prior paragraphs, APDIM strongly encourages CMS to clearly state that proxy salaries for *subspecialty* physicians originally trained in the specialty of the residents they are teaching be set to the salary of *specialists* in the residents' field regardless of the certification status of the faculty person.

Thank you for considering APDIM's comments on the proposed rule. Please contact APDIM Vice President for Policy Charles P. Clayton at (202) 861-9351 or cclayton@im.org with questions or comments about APDIM or this letter.

Sincerely,

Gregory C. Kane, MD
Chair
Public Policy Committee

cc: APDIM Council
APDIM Public Policy Committee
Charles P. Clayton

Submitter : Dr. John vanSchagen **Date:** 03/26/2007

Organization : Grand Rapids Family Medicine Residency Program

Category : Physician

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

I am the Program Director for a Family Medicine Residency program which trains 27 family physicians each year. Our residents receive the majority of their didactic teaching in the hospital setting as we have lectures on-site every Tuesday morning.

However, our residents do go to specialists offices for many of their outpatient rotations to learn about cardiology, orthopedics, neurology, endocrinology, etc. When they are in a specialist's offiee, our residents are seeing patients with the attending, so this is direct patient-care, not didacties. I would estimate that no more than a few minutes per day is spent in pedagogic activity in a day of patient care with a specialist. Thus the premise of the proposed Hospital Direct and Indirect Medical Education Policy Change is flawed in that it overestimates the amount of didactics that occurs away from the hospital setting. Implementation of this policy change will result in a needlessly expensive and arbitrary payment to preceptors who have traditionally provided their expertise either voluntarily or for a smaller flat stipend. If this proposal is implemented, I believe many primary care training programs will need to pay too much to have their residents properly trained in outpatient medicine, or they will need to down-grade the teaching experiences to limit ambulatory patient care with the highest-paid specialists. This would be an unacceptable compromise.

I thank you for the opportunity to comment on this important policy matter.

Submitter : **Mr. Robert Ortenzio** **Date: 03/26/2007**

Organization : **Select Medical Corporation**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1529-P-90-Attach-1.DOC

#90

March 26, 2007

BY ELECTRONIC FILING

Hon. Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1529-P
Mail Stop C4-26-5
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: ***Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes; Proposed Rule, 72 Fed. Reg. 4776 (February 1, 2007)***

Ladies and Gentlemen:

This letter presents the comments of Select Medical Corporation ("Select") concerning the proposed policy changes to the prospective payment system for long-term acute care hospitals ("LTCH PPS") for rate year ("RY") 2008, as referenced above. In this letter, we offer our comments on proposed rules expanding the existing "25% rule" to free-standing long-term acute care hospitals ("LTCHs") and increasing the standard Federal rate for RY 2008 by 0.7%. We also comment on the discussion in the preamble suggesting further changes to the short stay outlier payment policy.

Select is a leading operator of LTCHs in the United States. As of December 31, 2006, Select operated 92 LTCHs in 26 states. LTCH patients have specialized needs, and serious and often complex medical conditions, such as respiratory failure, neuromuscular disorders, cardiac disorders, non-healing wounds and renal failure. These patients generally require longer lengths of stay than patients in a general acute care hospital and benefit from being treated in a long term care hospital that is designed to meet their unique medical needs. As an organization that is intimately familiar with the particular patient population impacted by the proposed rule, we appreciate the opportunity to provide our comments and insight.

As a member of the Acute Long Term Hospital Association ("ALTHA"), we endorse the comments submitted by ALTHA and offer these additional comments in order to stress issues of special significance, as well as to provide further insight to the considerable impact the proposed rule will have on LTCHs. We strongly urge CMS not to implement the proposed rule. We believe the policies advanced in the proposed rule are based on flawed and unsubstantiated assumptions regarding LTCHs and their patients. Like prior rulemakings in this area, the policies being proposed continue to ignore the recommendations offered by independent advisors

to Congress, a non-profit research organization, and industry and medical experts. We implore CMS to take a more comprehensive view of the LTCH PPS and to embrace the approach to facility and patient level criteria that has been repeatedly recommended to CMS and to stop arbitrarily limiting payment in a manner that deteriorates access to, and the quality of, LTCH services. At a minimum, CMS should delay changes in the LTCH PPS until prior rules have been fully implemented and the results of those changes have been studied.

I. EXECUTIVE SUMMARY

At least two of CMS's most significant policy changes are based on unsubstantiated assumptions that patients do not receive a full episode of care at a referring short term acute care hospital and that, as a result, all LTCHs are acting as extensions or units of short term acute care hospitals. We strongly disagree with these assumptions and urge CMS not to implement the proposed rule without further considering the impact of the radical changes being proposed in response to these assumptions (e.g. expansion of the 25% rule and changes in SSO policy). Available data shows that LTCH patients receive different treatments to address different clinical needs following a stay in a short-term acute care hospital. Furthermore, differences in the medical complexity and average length of stay of LTCH cases substantiate reimbursement at the LTCH PPS rate, not the IPPS rate. CMS has provided the public with no evidence that this type of relationship exists or that it is so prevalent as to require subjecting all LTCHs to severe payment limitations.

In the following discussion, we provide a brief summary of the regulatory history of LTCH PPS with a particular focus on changes to the SSO policy and implementation of payment limitations on admissions from short term acute care hospitals. A review of CMS policy since Congress mandated implementation of a prospective payment system for LTCHs reveals that CMS has repeatedly ignored calls to base changes in the LTCH PPS on the appropriateness of admissions. Instead, CMS continues to propose arbitrary admission thresholds and payment limitations that result in restricting access to LTCH services, regardless of the level of medical complexity of a particular case. Each change in policy proposed by CMS is based on an oft repeated assumption that patients are not receiving a full episode of care in a short term acute care hospital before their admission to the LTCH. The separateness criteria, the original 25% rules, changes to the SSO policy and changes suggested in the proposed rule are all based on an assumption that LTCHs continue the same episode of care initiated in the short term acute care hospital. Despite CMS's strong conviction to the contrary, the data shows that patients admitted to an LTCH following discharge from an acute care hospital have a different DRG upon discharge from the LTCH, which represents a separate and distinct episode of care.

As CMS continues to advance changes to LTCH PPS based upon flawed assumptions the consequences of these policies are increasingly shouldered by patients who are denied access to care in what would be the most clinically appropriate setting for their care. Before continuing to expand the policies of prior rule-makings, we call on CMS to take a meaningful look at the assumptions on which these policy alternatives are based and to supplant the proposed rules with policies reflecting a methodical approach to structuring payment for LTCH services. We ask that CMS consider alternatives to the expansion of the 25% rule and changes to the short-stay outlier policy that would more appropriately target any cases that, based on a meaningful analysis of data, are likely the result of inappropriate admissions to LTCHs. Specifically, CMS should establish patient and facility level criteria for LTCHs to better define the appropriate patient setting and medical conditions required for admission, rather than draw questionable assumptions about the appropriateness of admissions from a limited set of data. LTCHs currently use patient screening instruments to determine whether LTCH services are appropriate for medically complex patients. This is one of a number of defined facility and patient criteria

that have been proposed in federal legislation creating new LTCH certification criteria to better address CMS's stated concerns in this area. We believe a more focused approach to LTCH admissions is far superior to the arbitrary rule being proposed by CMS.

Either together or separately, the expansion of the 25% rule and the proposed SSO policy violate the statutory requirement that CMS reimburse LTCHs on a per discharge basis that reflects the differences in patient resources and costs experienced by hospitals having an average length of stay of greater than 25 days. The proposed policies will continue to erode the LTCH PPS by reimbursing LTCHs for fewer and fewer medically complex patients at the LTCH PPS rates. As illustrated in the following discussion of the history of the LTCH PPS, the proposed rule continues a series of initiatives by CMS to pay an increasing number of cases at the IPPS rate despite the medical complexity and length of stay required by an average LTCH patient. To remain a credible payment system and comply with the intent of its enabling legislation, the LTCH PPS must adequately reimburse LTCHs for the costs they incur in caring for Medicare beneficiaries. The cumulative effect of the proposed changes and past changes to the LTCH PPS will bring LTCH reimbursement below the cost of care. This level of reimbursement is unsustainable and will inevitably result in a decrease in access to LTCH services in spite of the increasing number of Medicare beneficiaries and the overall aging of the country's population.

Select encourages CMS to increase the standard Federal rate by the full market basket update and, in so doing, recognize the increase in the cost of providing hospital services. The cumulative effect of prior changes and the proposed changes to the LTCH PPS have driven margins below cost as the data from MedPAC implicitly recognizes after factoring in the impact of the proposed policies. Select rejects CMS's proposal to provide less than the full market basket update of 3.2% for RY 2008. An increase of less than the market basket will not account for the cost of goods and services required to deliver LTCH services and will result in rates below the cost of care. CMS cannot use an unsupported measure like "apparent" case-mix, something it has never adequately justified with publicly available data, to reduce the market basket increase. Moreover, CMS relies on an estimate of "apparent" case mix from a dated study of acute care hospitals. The "apparent" case-mix is not a factor that is relevant to the price of inputs generally, or the cost of providing LTCH services in RY 2008 specifically.

II. BACKGROUND

By statute enacted in 1983, Congress determined that hospitals treating patients with an average inpatient length of stay of greater than 25 days and otherwise meeting the Medicare hospital conditions of participation – that is, LTCHs – should be exempt from IPPS. See 42 U.S.C. § 1395ww(d)(1)(B)(iv)(I). CMS itself has recognized the Congressional purpose in excluding LTCHs from the payment system applicable to general acute care hospitals. As CMS has said, LTCHs "have few short-stay or low-cost cases, and might be systematically underpaid if the [IPPS] method applied. Thus, exclusion of entire long-term care hospitals from [IPPS] is appropriate." 59 Fed. Reg. 45389 (September 1, 1994). Congress' directive to recognize LTCHs as a distinct category of hospital provider has continued in place, and was effectively ratified in 1999 and 2000, when Congress mandated the development of a prospective payment system specifically applicable to LTCHs. LTCH PPS was implemented by CMS in 2002. On March 22, 2002, CMS published a proposed rule to establish LTCH PPS, and on August 20, 2002, CMS published a final rule instituting LTCH PPS. Generally, the August 2002 Final Rule provided for the payment of a fixed amount for an LTCH case based on the diagnosis related group (the "LTC-DRG") to which the patient is assigned.

In 1994, CMS expressed concern that some purported LTCHs may be effectively "part of" a general acute care hospital and therefore should not be recognized as exempt from IPPS.

Specifically, CMS concluded that a general acute care hospital that operates an LTCH on its campus may be able to shift its long-stay patients to the LTCH, retaining only short-stay patients, and thereby profiting inappropriately from IPPS. Further, CMS maintained that, unlike rehabilitation units and certain other units, Congress did not intend to permit IPPS-exempt LTCH units of general acute care hospitals. Thus, CMS developed a set of criteria to ensure that an LTCH located on the campus of a general acute care hospital (a "hospital within hospital" or "HIH") would be sufficiently distinct from the "host" hospital, rather than "a 'paper entity' for which the underlying reasons for exclusion do not apply". 59 Fed. Reg. 45391 (August 11, 2004).

In June 2004, the Medicare Payment Assessment Commission ("MedPAC") issued a report to Congress recommending the development of a new, clearer definition of LTCH care. In particular, MedPAC recommended that LTCHs "be defined by facility and patient criteria that ensure that patients admitted to these facilities are medically complex and have a good chance of improvement." In September 2004, CMS engaged Research Triangle Institute, International ("RTI") to study the feasibility of MedPAC's recommendations.

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

The final regulations of the August 2004 rule provide lower rates of reimbursement to HIHs for those Medicare patients admitted from their host hospitals that are in excess of a specified percentage threshold. For HIHs opened after October 1, 2004, the Medicare admissions threshold is 25%. For HIHs that meet specified criteria and were in existence as of October 1, 2004, which included all but two of our then existing HIHs, the Medicare admissions thresholds were phased-in over a four-year period starting with hospital cost reporting periods that began on or after October 1, 2004. These HIHs are not subject to the full impact of the 25% rule until their first cost reporting period beginning on or after October 1, 2007. The HIH regulations also established exceptions to the Medicare admissions thresholds with respect to patients who reach "outlier" status at the host hospital. Certain HIHs that were in existence on or before September 30, 1995, and certain satellite facilities that were in existence on or before September 30, 1999, referred to as "grandfathered" HIHs or satellites were also not subject to the payment adjustments for discharged Medicare patients admitted from their host hospitals in excess of the specified percentage threshold.

On July 9, 2004, MedPAC submitted comments to CMS concerning CMS's then-proposed 25% admissions threshold for HIHs. MedPAC did not endorse CMS's proposal, but rather expressed concerns about it and suggested the need for more empirical evidence and analysis prior to the development of appropriate policy. Specifically, among other things, MedPAC noted that the 25% admissions threshold would do nothing to "ensure that patients go

to the most appropriate post-acute setting". MedPAC also noted that it has declined to recommend a moratorium on new LTCH HIHs in response to growth in the number of these facilities since, MedPAC believed, further analysis of the risks posed by LTCH HIHs should take place first. Similarly, MedPAC declined to endorse the 25% admissions threshold for HIHs, noting the need for more evidence of the unique risk posed by these facilities.

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

In the January 2006 proposed rule, CMS implied that it may expand the application of 25% admissions threshold to freestanding LTCHs. In its discussion, CMS suggested that, as a result of the imposition of the 25% admissions threshold for LTCH HIHs, there has been unwarranted growth in the number of freestanding LTCHs. Further, CMS claims that, "based on inquiries from LTCHs and their attorneys or agents" and from fiscal intermediaries, some host hospitals within the same community are arranging to cross-refer to another's co-located LTCH HIH. Again, without any meaningful supportive data, CMS expressed the very same concerns that it claimed to have with respect to LTCH HIHs – namely that LTCHs are functioning as long-stay units of general acute care hospitals, treating patients who have been inappropriately admitted to LTCHs for financial rather than clinical reasons, and causing Medicare to pay twice for what would essentially be one episode of care. CMS also proposed to radically change the method for determining the payment amount for SSO cases in the January 2006 proposed rule. In particular, CMS proposed 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.

On May 2, 2006, CMS released its final annual payment rate updates for RY 2007, which varied significantly with the proposed rule. For discharges occurring on or after July 1, 2006, the rule changed the payment methodology for Medicare patients with a length of stay less than or equal to five-sixths of the geometric average length of stay for each LTC-DRG (referred to as "short-stay outlier" or "SSO" cases). Payment for these patients had been based on the lesser of (1) 120 percent of the cost of the case; (2) 120 percent of the LTC-DRG specific per diem amount multiplied by the patient's length of stay; or (3) the full LTC-DRG payment. The May 2006 final rule modified the limitation in clause (1) above to reduce payment for SSO cases to 100 percent (rather than 120 percent) of the cost of the case. The final rule also added a fourth limitation, capping payment for SSO cases at a per diem rate derived from blending 120 percent of the LTC-DRG specific per diem amount with a per diem rate based on "IPPS". Under this methodology, as a patient's length of stay increases, the percentage of the per diem amount based upon the IPPS component will decrease and the percentage based on the LTC-DRG component will increase. In addition, for discharges occurring on or after July 1, 2006, the May

2006 final rule provided for a zero-percent update to the LTCH-PPS standard federal rate used as a basis for LTCH-PPS payments for RY 2007.

In January 2007, RTI released its final report making fifteen patient- and facility-level recommendations to CMS regarding the types of criteria needed to distinguish LTCHs from other types of hospitals. Among the fifteen recommendations, RTI proposed that CMS: (i) restrict LTCH admissions to cases that meet certain medical criteria; (ii) require LTCH admissions to be discharged if not having diagnostic procedures or improving with treatment; (iii) develop a list of criteria to measure medical severity for hospital admissions; (iv) standardize conditions of participation and set staffing requirements to ensure appropriate staff for treating medically complex cases; (v) maintain the 25-day average length of stay requirement; (vi) permit LTCHs to open certified distinct-part rehabilitation and psychiatric units; (vii) establish payment rules that discourage LTCHs from transferring cases early to other post-acute settings; and (viii) clarify the role of Quality Improvement Organizations in overseeing the appropriateness of admissions to LTCHs. In the February 2007 proposed rule CMS suggested that RTI's recommendations would require further study.

In the February 2007 proposed rule, CMS suggests expanding the payment limitation threshold to any LTCH or satellite of an LTCH that discharges during a single cost reporting period more than 25% (or applicable percentage for rural, single-urban, or MSA-dominant hospitals) of Medicare patients admitted from any non-co-located individual hospital. The proposed rule would apply to each individual hospital referral source to the LTCH and affect Medicare discharges from all LTCHs or LTCH satellites, regardless of whether the patient was admitted from a hospital located in the same building or on the same campus of the LTCH or satellite. The expansion of the 25% rule would occur in phases concurrent with the phase-in of the current 25% rule for LTCH HIHs and satellites of LTCHs. For LTCHs and satellites with cost reporting periods beginning on or after July 1, 2007 and before October 1, 2007, the percentage of Medicare discharges admitted from the referring hospital with no payment adjustment may not exceed the lesser of the percentage of the LTCH or satellite's Medicare discharges admitted from the referring hospital during the FY 2005 cost reporting period or 50%. For cost reporting periods beginning on or after October 1, 2007, the percentage of Medicare discharges admitted from any referring hospital without a payment adjustment may not exceed 25% (or the applicable percentage). CMS estimates that the expansion of the 25% rule will result in a 2.2% reduction in aggregate LTCH payments for RY 2008.

In the preamble to February 2007 proposed rule, CMS indicates that it is considering lowering LTCH payment to the IPPS rate for cases with a length of stay that is less than the average length of stay plus one standard deviation for the same DRG under IPPS (the so-called "IPPS comparable threshold"). Under the proposal, SSO cases with covered lengths of stay that exceed the IPPS comparable threshold would continue to be paid under the current SSO payment policy. Cases with a covered length of stay less than or equal to the IPPS comparable threshold will be paid at an amount comparable to the IPPS per diem. As justification for the change in policy, CMS cites DRG 475 (Respiratory system diagnosis with ventilator support) and DRG 483 (Trach with mechanical vent 96+ hours or PDX except face, mouth and neck diagnosis) as examples where the number of "recuperative" days are considerably shorter at the STACH if the discharge from the STACH was followed by an admission to an LTCH. CMS asserts that the discharge data for DRG 475 and DRG 483 support the belief that LTCHs are admitting some SSO patients who should have remained at the short-term acute care hospital. CMS advocates this change based on an assumption that the same DRG should not be paid more under LTCH-PPS if a covered length of stay in an LTCH is less than or equal to the IPPS average length of stay plus one standard deviation. CMS asserts that SSO cases with similar length of stays as the average length of stay of patients in a short-term acute care hospital who require similar

resources and, as a result, should be paid at the IPPS rate. CMS believes that it is "overpaying" for SSO cases in LTCHs with covered lengths of stay that are equal to or less than the typical IPPS average length of stay.

III. DISCUSSION

A. We urge CMS to reconsider the proposed rule in light of the facility and patient specific criteria recommended by MedPAC and RTI International and broadly supported by members of Congress.

The proposed rule continues to advance arbitrary limitations on payment and cause more and more cases to be subject to IPPS payment methodologies. Select believes this approach is counterproductive to the shared goal of providing quality LTCH-level services to Medicare beneficiaries in the most cost-effective manner. Rather than addressing the appropriateness of LTCH services for a particular patient, CMS continues to arbitrarily limit payment based on an assumption that all LTCHs are operating as units of short-term acute care hospitals and that patients who are admitted to an LTCH following a stay in an acute care hospital are receiving care for the same episode of illness that began in the acute care hospital. While we firmly believe that the data shows that these assumptions are entirely without merit, we urge CMS to take a more precise approach to addressing its concerns by supporting and implementing facility and patient level criteria for LTCH services.

In its June 2004 "Report to Congress," MedPAC recommended the adoption by CMS of new facility staffing and services criteria and patient clinical characteristics and treatment requirements for LTCHs in order to ensure that only appropriate patients are admitted to these facilities. CMS subsequently awarded a contract to RTI, to examine recommendations made by MedPAC concerning how LTCHs are defined and differentiated from other types of Medicare providers. RTI's Phase II report entitled "Long-Term Care Hospital (LTCH) Payment System Monitoring and Evaluation" was delivered to CMS in January of 2007. In its January 2007 final report, RTI made fifteen patient- and facility-level recommendations to CMS regarding the types of criteria needed to distinguish LTCHs from other types of hospitals. Many of RTI's recommendations support the initial recommendations of MedPAC regarding facility and patient level criteria.

In the February 2007 proposed rule CMS merely acknowledged that RTI's recommendations would require further study and, in some instances, action by Congress in order to accomplish certain recommendations. For its part, the United States Congress is already considering two bills, H.R.562 and S.338, which would better define LTCH care, in general, and help stabilize Medicare reimbursement to LTCHs in both a fair and predictable fashion. In light of the MedPAC recommendations from 2004, the recommendations of RTI and the very specific direction offered by H.R.562 and S.338, Select urges CMS to support restructuring LTCH reimbursement and certification system in line with MedPAC's recommendations and bills pending before Congress, rather than by expanding arbitrary payment limitations conceived to address perceived reimbursement imbalances, which both the 2005 MedPar data and MedPAC confirm do not exist. CMS has offered no reason for its failure to support and advance the MedPAC recommendations. Each rulemaking is another example of CMS's refusal to accept the expert advice of MedPAC and the industry.

B. The proposed rule increases the number of LTCH cases paid under IPPS methodology and, in so doing, violates the clear intent of Congress to recognize LTCHs as a distinct category of hospital provider.

In our comments to the annual payment update for RY 2007, we raised our concerns to CMS's initial suggestion to expand the application of the 25% rule. We now restate our opposition to the expansion of the 25% admissions threshold to freestanding hospitals grandfathered LTCH HIHs and admissions to HIHs and satellites from non-co-located hospitals. This policy violates the statutory requirement that CMS reimburse LTCHs on a per discharge basis that reflects the differences in patient resources and costs for hospitals having an average length of stay of greater than 25 days.

By threatening to impose the same types of payment adjustments adopted with respect to LTCH HIHs upon freestanding LTCHs that receive 25% (or the applicable percentage) of their admissions from a single general acute care hospital, CMS would be adding yet again to the number of LTCH cases that are paid under the IPPS methodology and, in doing so, would be violating the clear will of Congress in establishing LTCHs as a distinct, IPPS-exempt hospital provider type.

As noted above, Congress elected to define LTCHs as a separate hospital type in 1983, and ratified this decision in 1999 and 2000 with the mandate to establish LTCH-PPS, out of concern that IPPS methodologies would be inadequate to compensate these providers for the costs incurred in caring for medically complex, long-stay patients. Notwithstanding this plain legislative direction, CMS proceeded in August 2004 to impose the IPPS payment formula on LTCH HIH cases referred from the host hospital in excess of the 25% admissions threshold. In the May 2006 Final Rule, CMS departed further from Congressional intent by formally modifying its reimbursement policy for SSO cases by capping payment for SSO cases at a per diem rate derived from blending 120 percent of the LTC-DRG specific per diem amount with a per diem rate based on the general acute care hospital IPPS. Now, as part of the RY 2008 proposed rule, CMS is threatening to add an unknown number of freestanding LTCH patients and very short-stay patients to the class of long-stay patients whose care would be reimbursed under an IPPS payment methodology. These policy changes – individually and, most strikingly, in their cumulative effect – directly undermine the statutorily-mandated recognition of LTCHs as a distinct hospital provider type. To an ever increasing number of patients, LTCH services are no longer IPPS-exempt, but instead are subject to IPPS limitations. CMS has added layers of limitations over the years that together constitute de facto certification criteria that have not been authorized by Congress.

Further, CMS will not avoid the fundamental conflict between its contemplated proposal and the statutory LTCH definition by characterizing any payment adjustments to freestanding LTCHs as being "comparable" to amounts paid under IPPS. Use of the construct "comparable to" or "equivalent to" does not negate the actual effect of the action being considered – namely, to reimburse certain freestanding LTCH cases at rates developed for IPPS-reimbursed general acute care hospitals. CMS says as much itself when it justifies this policy on the view that freestanding LTCHs may be functioning as outgrowths of their general acute care hospitals from which they receive a high percentage of referrals, despite the absence of any evidence that such LTCHs are failing to meet the 25-day statutory certification standard. Using "comparable to" or "equivalent to" language, as CMS has with respect to the proposed expansion of the 25% rule and the proposed SSO policy changes, 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, as long as a hospital meets the statutory standard for LTCH certification – demonstrating an average Medicare length of stay of greater than 25 days – Congress has required that the facility be paid as an LTCH, not a general acute care hospital. Absent a shift in Congress's long-stated and unchanged position concerning the distinct status of LTCHs, CMS lacks the authority to adopt a payment methodology for LTCH cases that equates them with cases treated by an IPPS-reimbursed facility. To do otherwise violates CMS's regulatory authority. As currently proposed, extending the 25% admissions threshold to freestanding LTCHs exceeds any reasonable interpretation of the statute directing CMS to implement the LTCH PPS.

CMS refuses to adopt changes to the LTCH PPS recommended by MedPAC and RTI because of a concern that such changes require Congressional approval while simultaneously adopting policies that have a greater impact on the payment system. In a short discussion of the RTI Phase II report, CMS states that "[m]ost significantly, we are concerned that several of RTI's recommendations may require statutory changes. Furthermore, even among those recommendations for action that would be accomplished on a regulatory level, there are many significant issues that require further analysis." 72 Fed. Reg. at 4818 (February 1, 2007). The policies advocated by MedPAC and RTI, such as patient and facility level criteria, are designed to ensure that LTCH's admit only patients requiring long-term hospitalization for clinically complex illness. This is the same concern CMS's cites in justifying the proposed rule. The critical difference is the fact that the proposed rule is overboard, unduly punitive and weakens the LTCH PPS. If CMS does not have the authority to implement the MedPAC recommendations, it can not have the legal authority to implement the proposed rule.

C. Expansion of the 25% Rule to Freestanding LTCHs is wholly based on a flawed and unsubstantiated assumption that all LTCHs are furnishing inappropriate care.

The February 2007 proposed rule would expand the current Medicare admissions threshold to Medicare patients admitted from any individual hospital. Currently, the admissions threshold is applicable only to Medicare admissions from hospitals co-located with a LTCH or satellite of an LTCH. The original policy was based on CMS's assumption that host hospitals may be prematurely discharging patients to co-located LTCHs. Now citing a concern that short-stay acute care hospitals are prematurely discharging to non-co-located LTCHs, CMS proposes to expand the rule. If the proposed rule is adopted, free-standing LTCHs and grandfathered LTCH HIHs would be subject to the Medicare admission threshold. In addition, HIHs and satellites would be subject to the Medicare admission threshold for admissions from non-co-located hospitals. To the extent that discharges from an LTCH that were originally admitted from an individual hospital (regardless of whether the referring hospital is co-located with the LTCH or LTCH satellite) exceed 25%, or the applicable percentage threshold, during a particular cost reporting period, the payment rate for those discharges would be an amount equivalent to what Medicare would otherwise pay under IPPS.

1. There is no evidence to support the assumption that CMS is paying twice for the same episode of care, or that freestanding LTCHs are acting as units of referring hospitals.

The extension of the 25% rule to admissions from hospitals that may have no physical, contractual or other relationship with the LTCH is an inappropriate and arbitrary way to address concerns about premature discharge and inappropriate admissions. The proposed SSO policy is based on the argument that, if more than 25% of an LTCHs admissions come from an individual acute care hospital, the LTCH is acting as a unit of the short-term acute care hospital and CMS

presumes that the discharges and admissions were inappropriate. This argument says nothing about the fact the percentage of an LTCH's admissions from a single hospital has no correlation to whether the LTCH is functioning as a unit of a short-stay hospital or the appropriateness of LTCH care. Consider, for example, a 30 bed LTCH with more than 25% of its patients coming from independent 1000 bed acute care hospital. The LTCH's acceptance of a patient discharged from the large acute care hospital is of little significance to the acute care hospital when considering all of the post-acute care required by its patients. If CMS wants to make presumptions about an LTCH serving as a unit of an acute care hospital, CMS should be measuring the percentage of IPPS discharges to an LTCH, not the percentage of LTCH admissions from an IPPS hospital. Concerns about the behavior of the IPPS hospitals should be addressed with policies that impact IPPS hospitals.

Despite alleging otherwise, CMS has not provided data establishing that LTCH patients routinely continue the same episode of care that began in the acute care hospital. The contractor hired to examine this issue on behalf of CMS, RTI, concluded that this issue is "poorly understood." Accordingly, we urge CMS to delay adopting the proposed rule until CMS studies the impact of the existing 25% rule and presents findings that support this policy change. Stating that there is a "concern" that patients may be shifted to LTCHs is an insufficient reason to restrict patient access to care and interfere with medical decision-making.

In the preamble to the proposed rule, CMS states that there is minimal difference in the pre-discharge ALOS in an IPPS hospital for patients admitted to a co-located LTCH and a freestanding LTCH. Upon reviewing 2004 MedPar files, CMS found that "[g]enerally, the data reveals minimal differences for cases grouped to the same DRG between the ALOS at the acute care hospital prior to an admission to a co-located LTCH and the ALOS at a referring acute hospital prior to admission to a free-standing LTCH." 72 Fed. Reg. at 4812. In response to this, CMS assumes "that this data indicates considerable similarity between the patient shifting behavior at acute care hospitals and co-located LTCHs and acute care hospitals and LTCHs that are not co-located." Id. CMS says that it "would have expected" that the ALOS for patients discharged to a non-co-located HIH would be higher. Rather than using the new data to question its prior assumptions about inappropriate patient shifting to co-located LTCHs, CMS instead casts doubt on all LTCHs by jumping to the conclusion that its previous baseless assumptions about inappropriateness of admissions to co-located LTCHs applies also to freestanding LTCHs. With additional study, CMS would find that the ALOS is similar in each case because LTCH patients receive the same full episode of care that other patients receive at the short-term care hospital.

We question whether CMS has any basis for extending the 25% rule to freestanding LTCHs and grandfathered HIHs given the evidence offered in support of the original 25% rule. A FOIA request by Reed Smith LLP on May 18, 2004 asking for evidence supporting the original 25% rule revealed that CMS did not have the support it stated it did when that rule was proposed. Reed Smith requested any written information that CMS reviewed and/or relied upon in developing the proposed changes to criteria for classification of hospitals-within-hospitals, which included the then proposed 25% rule. Out of a total of 120 pages of documents identified as responsive to the FOIA request, CMS released 60 pages in full and 2 pages in part. The documents made available by CMS provided no substantive material supporting the reasons for implementing the 25% rule and did not justify the implementation of a wide ranging payment limitation. The response consisted entirely of copies of emails and written correspondence from attorneys requesting guidance on how to interpret either the 25% rule or the separateness criteria. The only conclusion these documents support is that providers are generally confused in how the rules impact providing long-term acute care services. This lack of support for the original 25% rule brings into question the support CMS has to expand the policy to all LTCHs.

by LTCH location. In other words, CMS would calculate the Medicare admissions threshold on a "site specific" manner, rather than by Medicare provider number and regardless of which provider is a multi-campus facility. As a reading of the proposed rule and the accompanying preamble may lead to several interpretations of how the 25% rule would be applied in this scenario, we ask that CMS clearly state in the rule that calculation of the admission threshold will be conducted in a "site specific" manner.

As stated above, the existing 25% rule has been implemented on a "site specific" manner. On August 11, 2004, CMS published the final rule implementing 42 C.F.R. § 412.534. Comments to the final rule indicate that section 412.534(d) is limited in its application to patients discharged from a hospital facility located on the same campus or in the same building. In the comments CMS described the reason for the payment limit as follows:

> We are finalizing this policy because we are concerned that the co-location of an acute hospital and a LTCH with significant patient movement from the acute hospital to the LTCH may violate the intent of the prohibition of LTCH units under section 1886(d)(1)(B) of the Act, a prohibition that was established in order to protect the Medicare system against unnecessary and inappropriate payments. We are finalizing a payment policy premised upon the fact that LTCH HwHs or satellites that admit more than a specified percentage of patients from their hosts are functioning as units to the LTCH HwH or satellite accordingly.

Accordingly, the purpose of the rule is to ensure that LTCHs do not function as a unit of the hospital when the LTCH shares a building or campus. CMS defines the term "campus" at 42 C.F.R. § 413.65(a)(2) to mean "the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus." As recent as the January 2006 proposed rule, CMS has stated that "the present 25 percent policy is being implemented in a location- specific manner, which means that the computation of the percentage of LTCH HwH or LTCH satellite discharges admitted from a host is based solely on the admissions from the physically co-located host and not from other campuses or remote locations which may share a common Medicare Provider number with the host." 71 Fed. Reg. at 4697 (January 27, 2006).

In response to previously requested technical advice, we understand that the CMS Central Office has instructed the Regional Offices that § 412.534 should be implemented so that only facilities actually onsite (at the same physical location or within 250 yards of each other) with a LTCH or a LTCH satellite are subject to the host hospital relationship. Considering the original intent of 42 C.F.R. § 412.534, prior guidance from CMS and implementation of the existing 25% rule, the admission threshold can only be applied on a site specific manner. To do otherwise would further compromise the LTCH PPS by subjecting additional LTCH cases to IPPS payment formula.

In discussions with agency officials regarding this approach, CMS has raised the concern that a referring short-term care hospital may transfer a patient to another campus of the referring hospital in order to avoid the 25% rule limitation. We believe this scenario to be troubling as well, but doubt that it occurs even in the most rare of circumstances. This is an unlikely practice because the transfer must be medically justified and there is no medical reason in this scenario. To the degree CMS identifies this as an on-going occurrence, a far better approach is to address

this scenario by specifically prohibiting it, rather than assuming this extraordinary example is the norm.

D. ***LTCHs have no means of determining which cases are high cost outliers for purposes of maintaining compliance with the proposed 25% rule.***

CMS has failed to consider the practical considerations of how LTCHs will comply with the proposed rule. Unlike an HIH that necessarily has a contractual relationship with its host hospital through which it can mandate the receipt of data from the host, a freestanding LTCH or HIH generally has no contractual relationship with other hospitals that refer so LTCHs lack the ability to require the referring hospital to furnish information necessary to address this requirement. Furthermore, the LTCH PPS provides no mechanism for general acute care hospitals to share outlier data with LTCHs in order to monitor compliance with the 25% rule. While the rule requires that LTCHs exclude from the 25% calculation all patients "on whose behalf a Medicare outlier payment was made to the referring hospital," LTCHs have no practical means of determining which patients were outliers at the general acute care hospitals. This requirement presents a significant challenge to freestanding LTCHs. There is no standard communication from the referring hospital that provides the data necessary for the LTCH to make such a determination. It is up to the LTCH to establish a relationship with each and every referral source. Even then, the LTCH is totally dependent upon the accuracy of the data supplied by the referring hospital. It is not unusual for the referring hospital to be unfamiliar with the payment status of the patient at the time of admission to the LTCH, or for the referring hospital to submit final bills on its discharged patient well after the admission at the LTCH. Also, if changes occur to the Medicare bill as a result of a review by CMS or the fiscal intermediary, the referring hospital most likely would not contact the LTCH about a change in patient status. Currently there is nothing that compels a referring hospital to cooperate with the LTCH in this regard.

While the existing 25% rule excludes outliers in the calculation of the payment limitation threshold, relationships between co-located hospitals is significantly different than the typical interactions of non-co-located hospitals. A LTCH HIH has greater access to staff of the co-located hospital who can more easily provide and confirm outlier data. By its own rules, CMS acknowledges the difference in relationships between co-located hospitals and non-co-located hospitals. Freestanding LTCHs typically do not have regular interaction with non-co-located hospitals. Furthermore, patient medical records and other information conveyed to the LTCH as part of a patient's admission will not describe whether a Medicare outlier payment was made to the referring hospital. We know from reviewing MedPar data that acute care hospitals are not consistently coding patients discharged to LTCH's appropriately, which hinders our ability to utilize the data to determine their volume of high cost outliers.

As the rule has been proposed, it will be extremely difficult for non-co-located LTCHs (e.g. LTCHs accepting patients discharged from hospitals not located on the same campus or in the same building) to monitor compliance with the 25% admission limit during any single fiscal year. Without adequate assurance that it has not exceeded the admission threshold, an LTCH is exposed to an unquantifiable degree of risk of being assessed an overpayment at the end of each cost reporting year. In the August 11, 2004 final rule establishing the 25% rule, CMS stated a clear interest in adopting a payment limitation on admissions from co-located hospitals that "fiscal intermediaries would be able to evaluate annually in an efficient manner without the involvement of corporate attorneys and a yearly reevaluation of corporate documents and transactions." 69 Fed. Reg. 4,9194. While fiscal intermediaries may be able to efficiently determine compliance with the proposed rule long after the end of an LTCH's cost reporting year, the same is not true for LTCHs themselves. Furthermore, the financial implications of

noncompliance make it essential that LTCHs can effectively monitor compliance on an ongoing and timely basis. As the rule has been proposed, LTCHs will face an unacceptable degree of uncertainty.

CMS has yet to define the process that will be used to monitor an LTCH's compliance with the 25% limit. There is no definitive document or set of documents that LTCHs are instructed to rely upon in self-monitoring towards this goal, nor is there any guidance provided by CMS as to the manner in which they will gauge a hospital's compliance.

There is a limited exception to the proposed 25% rule for LTCHs that are in an "MSA-dominant" hospital. An MSA-dominant hospital is a facility that discharges more than 25% of the patients in the MSA in which it is located. This exception allows the LTCH to accept the percentage of patients that the MSA dominant hospital is responsible for discharging in that MSA, but no more than 50%. This presents an exceptional monitoring challenge to the LTCH. In measuring its ongoing compliance with this restriction, the LTCH would need to know the percentage of discharges at the MSA dominant hospital on an ongoing basis. During its cost reporting year, an LTCH has no mechanism for determining what percentage of discharges the MSA dominant hospital is responsible for in the MSA. As drafted, the proposed regulation does not describe any method for computing this percentage, or define how CMS will monitor compliance with the percentage. Both should be clear to the LTCHs in order to eliminate confusion and financial risks.

If CMS proceeds with the proposed rule, we would expect that it provide LTCHs with this important information or develop a mechanism for the general acute care hospitals to provide us this information.

E. CMS indicates it is considering a change in the short stay outlier policy without providing specific regulatory language or offering data to support a change in policy.

In the preamble to the proposed rule, CMS stated that it is considering a change to the SSO policy, and requested comments on the proposed policy. CMS indicates that it is considering lowering LTCH payment to the IPPS rate for cases with a length of stay that is less than the average length of stay plus one standard deviation for the same DRG under IPPS (the "IPPS comparable threshold"). Under the proposal, SSO cases with covered lengths of stay that exceed the IPPS comparable threshold would continue to be paid under the current SSO payment policy. Cases with a covered length of stay less than or equal to the IPPS comparable threshold will be paid at an amount comparable to the IPPS per diem.

CMS advocates this change based on an assumption that the same DRG should not be paid more under LTCH-PPS if a covered length of stay in an LTCH is less than or equal to the IPPS average length of stay plus one standard deviation. CMS incorrectly assumes that SSO cases with similar length of stays as the average length of stay for short-term acute care hospital patients require similar resources and, as a result, should be paid at the IPPS rate. CMS believes that it is "overpaying" for SSO cases in LTCHs with covered lengths of stay that are equal to or less than the typical IPPS average length of stay.

CMS's assumption that patients whose lengths of stay fall below the IPPS comparable threshold have been inappropriately admitted to the LTCH is flawed on numerous grounds. First, this assumption, which supposes that a majority of patients whose length of stay is below the average were inappropriately admitted, is at odds with the premise of LTCH PPS, which necessarily recognizes that the lengths of stay of about half of all LTCH patients will be below

the average. By removing these cases from LTCH PPS CMS disrupts the averages required to make the prospective payment system work. Second, CMS's assumption fails to recognize that, demonstrably, SSO patients require the same intensity of care that LTCHs furnish to inlier patients. Third, CMS erroneously assumes that it is possible to distinguish SSO cases from inlier cases at the time of LTCH admission.

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

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.

By proposing to pay cases in the IPPS comparable threshold 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.

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.

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

SSO patients require the intensive resources and care management available in an LTCH. The diagnoses, medical complexity and severity of illness of SSO patients are generally no

different from the overall LTCH patient population. Whether a particular LTCH patient ultimately falls into the category of the IPPS comparable threshold does not in any way suggest that the patient was inappropriately admitted to an LTCH and did not need LTCH care. Appropriately, the LTCH stay is an additional incremental hospital stay. It's inappropriate to conclude that the LTCH stay is effectively part of the IPPS hospital stay.

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

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

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

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

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

In addition, another 2 percent of Select's SSO patients are characterized as such because their Medicare coverage expires during their LTCH stay but before they reach the relevant SSO thresholds. Clearly, loss of Medicare coverage bears no relevance whatsoever to whether the patient was appropriate for admission to an LTCH. CMS, itself, recognized this fact in the initial

implementation of LTCH PPS, when it decided to count total patient days rather than Medicare-covered days to determine whether an LTCH meets the statutory average length of stay requirement for certification:

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

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

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

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

Consistent with the fact that SSO patients require the same level of care as inlier patients, LTCHs are unable to distinguish between these two patient populations at the time of admission. (For the same reason, LTCHs are also unable to identify high cost outliers at the time of admission, and are unable to predict the patient's outcome, including death, at the time of admission.) Data show that patients who are ultimately characterized as SSO cases present the same diagnostic mix, same or higher levels of severity and higher risks of mortality than inlier cases. In 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.

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.

4. The proposed SSO policy would create a "payment cliff" that, in turn, would results in exactly the incentive that CMS sought to prevent in all prior rulemaking.

In the proposed rule CMS is considering whether to create an additional limitation that would lower payment to the IPPS rate for SSO cases that have a LOS equal to or less than the IPPS geometric LOS plus one standard deviation for the same DRG under IPPS (referred to as the "IPPS comparable threshold"). This limitation would decrease payments to applicable cases

to a level less than the blended limitation. In the May 2006 final rule CMS created a blended payment limitation in addition to reducing the existing limitation based on the cost of care from 120% to 100%. This approach has made the cost of care in 30% to 35% of Select's LTC-DRG 550 cases higher than the expected reimbursement and the cost of care in the remainder of these cases equal to, but no greater than, the expected reimbursement. CMS does not adequately justify paying for these cases under a methodology that would systematically pay at or, in approximately one-third of cases, below cost. It is perverse application of the prospective payment system to pay for a majority of a type of case below cost, especially since the only justification is the length of stay of that case. The change in SSO policy in May of 2006 has already created substantial financial burdens on the cost of providing care.

First, the payment rates result in payment substantially below cost since the current limitations already result in loss or, at most, payments that break even with costs. As a result LTCHs already have no incentive to admit SSO cases and, therefore, further cuts aren't needed. Second, the methodology actually results in lower total payments to LTCHs for SSO cases than what IPPS hospitals receive. This is a result of IPPS hospitals receiving the full DRG rate, even for short stay cases and LTCHs subject to the blended per diem until the LOS reaches the IPPS DRG rate, and only then is an LTCH case subject to the IPPS DRG rate. This not only shows the inadequacy of payment to LTCHs, but also shows that the approach is inconsistent with the basis of IPPS DRGs (an average rate where the full rate for short stay cases offsets the excess costs for longer stay cases). Finally, the effect of the proposed policy is a payment cliff at the end of the IPPS DRG ALOS plus one standard deviation. Implementing the SSO policy under consideration would create a payment cliff by paying dramatically different amounts for cases with similar lengths of stay on either side of the IPPS comparable threshold. A difference in one day will result in substantial payment increases in the LTC-DRGs we reviewed. This is exactly the situation CMS claims it would like to avoid. In the preamble to the proposed rule, CMS states that "[w]e continue to believe that this specific methodology, which results in a gradual increase in payment as the LOS increases without producing a significant payment "cliff" at any one point, provides a reasonable payment option under the SSO policy." As demonstrated above, the proposed policy does not meet CMS's own expectations and, therefore, should not be considered further.

CMS has not addressed previous valid concerns that a change in SSO policy that addresses what are considered very short stay outliers will create a significant payment cliff. This is not the first policy offered by CMS to suffer this problem and CMS has not explained how this new SSO policy would alleviate past concern. In the March 2002 proposed rule CMS included a special payment provision for very short stay discharges, which were defined as having a LOS of 7 days or less. In rejecting the proposed policy in the August 2002 final rule implementing the LTCH PPS, CMS acknowledged a concern that the policy would create a "cliff" effect. Discarding the very short stay policy, CMS established "a payment category for shorter stays that, in an increasing progression, reflects the episode of care." 67 Fed. Reg. 56001 (August 30, 2002). CMS recognized this approach as "effectively and equitably address[ing] the problem of treating short-term patients in a LTCH" Id. CMS offers no explanation now why the payment cliff created by the proposed rule is acceptable.

5. Contrary to the rationale provided to support the proposed policy, there is no relationship between the percent of high cost outlier cases in acute care hospitals and the percent of discharges to LTCHs.

CMS is relying on incomplete and faulty data concerning IPPS hospital behavior to support the SSO proposal. CMS is basing the SSO proposal on data that it believes shows that IPPS hospitals are using LTCHs as the site to receive HCO patients that should be paid under

IPPS. (Presumably, Table 5 at 72 Fed. Reg. 4806 is CMS's data.) In fact, there is no relationship between the percent of high cost outlier cases in acute care hospitals and the percent of discharges to LTCHs. If anything, the data show the opposite, i.e., as the percentage of acute hospital discharges to LTCHs increases, the percentage of high cost outliers in acute hospitals also increases, albeit only slightly. The same pattern holds if the percentage of Medicare reimbursement spent on high cost outliers is used rather than the percentage of high cost outliers. This indicates that, in fact, LTCHs are not treating patients that would otherwise have continued to receive care in an IPPS hospital and been paid for as an HCO.

We have reviewed the bar and scatter graphs prepared by ALTHA as an analysis of all LTC-DRGs and the 10, 20, 30 and 50 most frequent LTC-DRGs with the most frequent acute hospital discharges to LTCHs, as well as the highest frequency discharge, LTC-DRGs 541 and 542. The graphs provided by ALTHA accurately demonstrate what Select has found to be true: the percentage of high cost outliers in acute care hospitals actually increase slightly as the percentage of discharges to LTCHs increases. This is directly contrary to CMS's stated concern that the prevalence of an LTCH lowers the percentage of high cost outliers in a neighboring short-term acute care hospital. This data is enormously significant in correcting the false assumptions on which CMS has justified numerous changes to the LTCH PPS, including the SSO policy and the 25% rule.

F. CMS should provide the full market basket update of 3.2% for RY 2008.

1. An increase of 0.7% in the standard Federal rate is inadequate and does not cover the reasonable and necessary cost of LTCH services.

Each year since implementation of LTCH PPS in August of 2002, and in some cases twice during t he same year, CMS has implemented changes to LTCH PPS designed to slow growth in the number of new LTCHs and reduce margins. Now in 2007, CMS again proposes a series of policies that will reduce payments to LTCHs. In addition to expanding the 25% rule and decreasing payment to short-stay cases, CMS proposes to limit the increase in the standard Federal rate to 0.71%, which is 2.49% below the estimated price inflation using the Rehabilitation, Psychiatric, Long Term Care ("RPL") market basket. The cumulative effect of all of CMS's policy changes since 2002 has been to drive revenues below costs and completely halt, if not reverse, growth in the number of LTCHs.

Without considering the reduction in payments that would result from the proposed rule, MedPAC estimates margins at or near zero. If the proposed changes are factored into current estimates, margins fall well below costs. Select has reviewed estimates generated by ALTHA showing estimates for RY 2008 to be between negative 3.7% and 5.7%. ALTHA's estimates accurately reflect the impact of the proposed rule and highlight the significant damage the proposal will cause if CMS fails to provide the full market basket update of 3.2%.

CMS's own data showing the lack of growth in the number of LTCHs is further evidence of the cumulative impact of past changes to the LTCH PPS, as well as policies in the proposed rule that were previously discussed. In 2006 there was a net reduction of one LTCH enrolled in the Medicare program. This net reduction comes at a time when the total number of Medicare beneficiaries continues to increase. Just between July 2004 and July 2005 CMS reported a growth in Medicare beneficiaries of 666,122. The Medicare-eligible population is projected to grow from 35.1 million in 2000 to 69.7 million by 2030. The medical community agrees that serious, medically-complex conditions will continue to require long-term hospital services for

this growing population. In light of the inevitable increase in LTCH services, it is unconscionable for CMS to continue to expand arbitrary payment limitations in order to hold or reduce the number of existing LTCHs. Furthermore, it is inappropriate for CMS to single out LTCHs from other post-acute care providers. The growth of LTCHs was a response to medical need and the success of LTCH services in addressing those needs. Further payment limitations and failure to address increases in the cost of providing services are punitive in nature and excessive when growth in LTCHs has stopped and margins are already at or near zero.

2. Basing the market basket almost entirely on changes to the case-mix in prior years is an inaccurate and irrelevant means of updating the standard Federal rate.

CMS bases the proposed reduction in the market basket update on increases in the "apparent" case-mix from previous years. CMS defines "apparent" case-mix increases as that portion of the total increase in the case-mix index due to changes in coding practices, as opposed to "real" increases that result from the treatment of more resource intensive patients. No where in the Code of Federal Regulation does CMS state that a function of the market basket is to account for changes in case-mix attributable to "apparent" case-mix or state that the standard Federal rate may be adjusted for "apparent" case-mix. At § 412.523 CMS lists adjustments it may make to the standard Federal rate, including adjustments for outlier payments, budget neutrality during the transition, and a one-time budget neutrality adjustment. Case-mix changes, "real" or "apparent" are not mentioned. Any relevance that so-called "apparent" case mix may have is in the context of annual re-weighting of the LTC-DRGs, not the market basket update.

Even if an adjustment to the market basket based on case-mix were appropriate, there is no basis for reducing the RY 2008 market basket update based on claims data of FY 2004 and FY 2005. Other than the unavailability of data, CMS provides no logical explanation as to why an estimation of the "apparent" increase in case-mix derived from FY 2004 and FY 2005 claims should be applied to the market basket increase for RY 2008. This data has no relevance to changes in the price of LTCH services.

If CMS is to consider past increases in the "apparent" case-mix in establishing the standard Federal rate, then CMS should also consider the compounding effect of past changes to the LTCH PPS, including reweighting of LTC-DRGs, limitations on SSO payment and the implementation of the 25% rule on HIHs and satellites. These changes are as relevant to the market basket update as the case-mix index.

IV. CONCLUSION

CMS should not implement the proposed rule. Instead, CMS should carefully reconsider the assumptions made in the policies being offered and adopt an approach that more targets cases that, based on a meaningful analysis of data, are likely the result of inappropriate admissions to LTCHs. There is no data to support a concern that general acute care hospitals are systematically discharging short stay patients "early" to LTCHs in order to maximize profits. In fact, the data confirms that LTCHs are treating patients for a separate and distinct episode of illness that is characterized by complex clinical needs and typically a higher severity of illness and risk of mortality.

The proposed rule has failed to consider the impact these policies will have on the LTCH PPS and the quality of health care services being offered to Medicare beneficiaries generally. CMS has also failed to explain important details on how the rule will be implemented. The

proposed policy should clearly state that the calculation of the admission threshold will be conducted in a "site specific" manner. Furthermore, CMS should propose for comment how LTCHs will monitor compliance with the 25% rule by offering a mechanism for identifying outliers at the referring hospital.

Finally, an increase of 0.7% in the standard Federal rate is inadequate and does not cover the reasonable and necessary cost of LTCH services. When considered in conjunction with the other policies discussed in the proposed rule the failure to adopt the recognized increase in the cost of providing LTCH services, as identified by the RPL market basket, will result in an erosion of the viability of the LTCH PPS. Reducing payment below cost and basing LTCH payment on IPPS per diem rates violates the statutory requirement that CMS reimburse LTCHs on a per discharge basis that reflects the differences in patient resources and costs for hospitals having an average length of stay of greater than 25 days. The statutory definition of an LTCH, the statutory directive for an LTCH PPS, and the entire framework of the LTCH PPS are based upon reimbursing LTCHs for Medicare inpatients who on average and in the aggregate have a length of stay of greater than 25 days. The policy CMS is proposing, as with prior policies, violates this cornerstone of LTCH reimbursement law and erodes the prospective payment system.

We would welcome the opportunity to meet with CMS's representatives to discuss further CMS's concerns and to assist in developing appropriate regulatory responses.

Very truly yours,

Robert A. Ortenzio
Chief Executive Officer

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

DOCSSFO-12472063.5-PPITTS

Submitter : LInda Glenn **Date:** 03/26/2007

Organization : University of South Alabama Hospitals

Category : Hospital

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

Often resident schedules are rearranged for changes in service opportunities in the training site beyond the control and foresight of the GME program. Also, residents may be picked up or may drop out of the GME program. These situations have been recognized by CMS previously in the rulemaking for hospital affiliation agreements for cap sharing such that CMS allows the contracts to be modified for rotational changes made during the agreement period. Similar provisions are needed in this nonhospital site rule allowing amendments to the contracts for true-up of cost calculations and payments as a result of rotational, resident, or faculty changes.

Submitter : **Dr. Judith Pauwels** **Date: 03/26/2007**

Organization : **University of Washington**

Category : **Physician**

Issue Areas/Comments

Background

Background

Family Medicine residency training programs have relied heavily since their inception on the teaching by community physicians in addition to that by employed faculty. The specialty is inherently broad, encompassing all fields of medicine including surgical as well as generalist disciplines. Regions of the country commonly served by family physicians, sueh as rural and urban underserved areas, require this broad training as essential to practice there as there is frequently limited or distant access to specialty services.

These community physician teachers across specialties have historically been "paid" by non-monetary means: the increased quality of care provided to their patients because of their being pushed to provide top-quality care; continuing medical education they receive through the stimulation of teaching; the pleasure of working with young physicians and the feeling of contributing to a useful activity; a shared sense of responsibility for the future of health care in this country. Some also receive other indirect rewards such as clinical teaching appointments in medical schools, access to internet or library resources, and reportable CME time. Many view these interactions as ways to attract physicians to their communities in the future, in lieu of hiring expensive recruiters.

These physicians are not required to participate in voluntary teaching activities; they choose to do so because the rewards they perceive are greater than the effort.

This rule change, which is an effort to provide clarity to a recurring question about Medicare payments to programs when residents are being taught outside of the main program, appears innocent on the surface but would gut most family medicine residency programs nationwide, forcing many to close. Currently, even with current financing of programs including GME monies, programs have been shown in studies to run a deficit averaging over $40,000 per resident, a deficit made up by supporting hospital systems. Reimbursements from clinical revenues have continued to decrease with increasing operating expenses, further exacerbating this deficit. Adding to this already very tenuous situation, which has already led to program closures, will be one more "straw that broke the camel's back".

The outcome will be far fewer residency programs in family medicine in this country. If that is the intent of CMS, this will be a successful outcome. However, if the intent is to control costs but maintain support for cost-efficient and needed specialties, this will lead to the worst possible outcome - a complete collapse of the primary care training base, with a return to entirely specialist-driven training programs.

GENERAL

GENERAL

In summary, the proposed policy would decimate Family Medicine training programs nationally, gutting the programs and leading to many program closures. This negative result is the opposite of what is needed to train family physicians for community practice.

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

I am writing to adamantly oppose this proposal.

The following are the most critical points regarding this proposal:

1. In CMS's effort to define "All Substantially All", the threshold of 90 % is far too high. This should be reduced to 75 % or below.
2. CMS should allow for physician volunteerism, for the indirect benefits of teaching to those teaching physicians noted in the first section.
3. CMS should allow programs / hospitals to exclude the costs of teaching physicians as part of the definition of "all or substantially all".
4. The 3 hours of non clinical didactic time should be decreased to 1 hour per week, as this most closely fits with the reality of this time in community preceptors offices. If the 3 hour non-clinical didactic per week rule is maintained, then that should be prorated for the number of clinics that the residents have with the preceptor per week, as on most rotations resident are not with the preceptor full-time.
5. Hospitals / programs that are over their cap on residency slots as determined by BBA or BBRA have no duty to fulfill the requirements of this rule as the Medicare program is not paying for such training.

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

As noted in the first section, this proposal will adversely affect the ability of Family Medicine programs to train Family Physicians in the breadth of experiences critical for their training. The proposed payments and requirements are overly burdensome and onerous. Additionally, the community teachers who are implicated in this solution to not identify a problem that needs to be fixed.

Specifically for the Family Medicine program where I am program director, having to pay for the community preceptors used for our resident training, most of whom already make far more than almost any family physician in this country and for whom even a fraction of their salary would be a significant additional payment, would lead to closure of my program.

Submitter : Mr. Don Romain **Date:** 03/26/2007

Organization : Spectrum Health Special Care Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1529-P-93-Attach-1.PDF

#93

Spectrum Health Continuing Care

Special Care Hospital
750 Fuller Avenue NE Grand Rapids MI 49503-1918
616 486 3691 fax 486 2689 spectrum-health.org

March 21, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1529-P
P.O. Box 8015
Baltimore, Maryland 21244-8015

Re: Comments on Medicare Program; 2008 Proposed Update Rule
Published at 72 Federal Register 4776 *et seq.*

Dear Ms. Norwalk:

Spectrum Health Special Care Hospital welcomes the opportunity to submit these comments on proposed rules published on February 1, 2007 at 72 *Fed. Reg.* 4776 et seq. This rulemaking seeks to make significant changes to the admission practices of long-term care hospitals (LTCHs) as well as payment policies.

Spectrum Health Special Care Hospital (provider # 232029) was established in 2001 as a freestanding long-term acute care facility and is located at 750 Fuller Ave. NE Grand Rapids, MI 49503 on the Kent Community Campus of Spectrum Health. It serves Medicare patients residing in West Michigan. We oppose CMS' proposed major changes for FY 2008 including:

- proposed expansion of the 25% rule to freestanding hospitals
- "consideration" of a policy to expand the short stay outlier ("SSO") payment policy to allow "extremely" SSO cases to be paid comparable to IPPS cases
- Inflationary update less than market-basket
- Significant increase to the outlier cost threshold

These proposed provisions are unsupported by facts, and contrary to the clinical and financial data available. The proposals would drastically reduce payments to Spectrum Health Special Care Hospital and force Spectrum Health Special Care Hospital to operate at a loss when treating Medicare patients, placing the continued operation of Spectrum Health Special Care Hospital and the patients it serves in jeopardy.

In the preamble to the update rule CMS states that LTCHs are behaving like a ACH, or like a step-down unit for a ACH, or that the patient presumably was discharged by the ACH to the LTCH during the same episode of care and the LTCH is not providing complete treatment. These statements are generalized and unsupported. CMS points to the statutory difference between LTCHs and ACHs that was intended to pay LTCHs based upon "the different resource use" of LTCHs as compared to ACHs. In fact, LTCHs do provide different services to patients, and patients in LTCHS do utilize

different resources than ACHs, making it inappropriate to pay LTCH discharges under the IPPS. CMS has presented no data to the contrary to support these proposals. RTI, contractor to CMS, noted in the Executive Summary of its report that "[u]nderstanding whether LTCH hospitals are substituting for services already paid to IPPS hospitals or whether LTCHs are providing specialized services is not well understood." 72 Fed. Reg. 4885. Physicians at ACHs in West Michigan use their skill and experience to discharge certain patients to Spectrum Health Special Care Hospital because of the specialized care they can receive at Spectrum Health Special Care Hospital. The care and services are different than that provided at an ACH, and such care, and the timing of such care, clearly are in the best interests of the patient's medical care. Spectrum Health Special Care Hospital provides an array of team-based services that can focus on the recovery of the whole patient, while the ACHs are typically "diagnosis focused" and provide critical care to acutely ill patients by focusing on a single clinical dimension. Spectrum Health Special Care Hospital helps patients recover all functions and return to the community or move on to the next appropriate level of care. ACHs simply are not designed to provide these services, and there is no current incentive for them to expend the significant resources to try to replicate those specialized services that already exist at Spectrum Health Special Care Hospital. The physicians at the ACH also make the medical determination of when the patient is appropriate to be transferred from the ACH to Spectrum Health Special Care Hospital based upon the patient's condition, medical needs, and availability of appropriate services. It is disturbing to think that a patient would remain at an ACH instead of being transferred to Spectrum Health Special Care Hospital, and thus delay (or eliminate entirely) the commencement of needed specialty services, purely for payment system reasons.

Expanded 25% rule

Currently LTCHs are in the third year of the transition, that began Oct. 1, 2004, that impacted the Medicare payment rate for discharges exceeding 25% from the host hospital. The proposed rule would **expand the 25% rule to all discharges regardless of the facility's ownership relationship.** CMS justifies this expansion of the 25% rule to freestanding LTCHs based on the presumption that the ACH's discharge to the LTCH presumably is a "premature discharge" if the patient has not reached cost outlier status at the ACH. As noted above, there is no clinical or financial evidence to support this conclusion. When commissioned by CMS, RTI investigated these issues and concluded that it cannot state that LTCHs are substituting for services already paid to IPPS hospitals. However, there is significant clinical and financial support (as submitted to CMS by the National Association of Long Term Hospitals) that ACH patients are discharged based upon the expertise of the ACH physician, who has determined that it is appropriate for the patient to receive the specialized services of the LTCH at that time in order to maximize the patient's recovery.

The proposal to expand the 25% rule fails to recognize the many localities in which LTCHs serve a small number of independent ACHs or in regions where the large ACHs are consolidated under a single provider number, such as in the case of Spectrum Health Special Care Hospital. These local conditions would make it impossible for Spectrum Health Special Care Hospital to satisfy the 25% rule.

Applying such an arbitrary Rule to penalize LTCHs will not only jeopardize patients' access to appropriate medical care, but the significant and inappropriate financial losses it will generate will all but guarantee the closure of a significant number of LTCHs, thereby preventing access to these unique services by many Medicare beneficiaries whom aren't located in regions of dense ACH presence.

Spectrum Health Special Care Hospital recommends that the CMS eliminate any expansion of the 25% rule.

Extreme SSO policy

As noted above, the extreme SSO policy being considered by CMS is contrary to clinical and financial realities. Under the current SSO policy a LTCH will at best receive only its cost for a SSO; there is no incentive for a LTCH to admit a patient who is likely to become a SSO. Under the extreme SSO policy being considered a LTCH would undoubtedly lose a significant sum on treating the patient.

Besides not having any financial incentive to admit an extreme SSO, CMS also assumes that LTCHs are able to predict, prior to admission, which patients will become SSOs, much less extreme SSOs. There is no way for Spectrum Health Special Care Hospital or it's physicians 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 Spectrum Health Special Care Hospital at the appropriate level of care based on the medical judgment of their treating physicians and the parameters of InterQual criteria. 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 Spectrum Health Special Care Hospital may become a SSO:

- Some 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.
- Other patients 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.

The proposed SSO rule would impose a payment adjustment as a mechanism to disqualify a patient for hospital services and intrude upon the West Michigan physician's ability to admit patients to Spectrum Health Special Care Hospital based on medical necessity, i.e., the need for specific programs of care and services provided.

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

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

Spectrum Health Special Care Hospital recommends that the CMS reject the extreme SSO policy under consideration.

Fiscal Year 2008 Update less than Marketbasket

The CMS' proposal to provide a 0.71% inflationary update, combined with the other proposed changes is unfair and unreasonable, denying LTCHs a full inflationary allowance. The lack of an update violates the fundamental principle that Medicare should at a minimum attempt to cover the costs associated with caring for patients, which in this case are the program's most medically complex patients. The CMS' proposal places the ongoing operation of Spectrum Health Special Care Hospital in jeopardy, reducing access to LTCH services for West Michigan citizens.

Spectrum Health Special Care Hospital recommends that the CMS include a reasonable (3.2 percent) market basket adjustment in the FY 2008 proposed rule.

Increase in Outlier Threshold

The CMS is proposing a twenty-six percent increase in the cost outlier threshold from the current $14,887 to $18,774. The rationale indicates that the current outlier payments are exceeding the outlier payment pool of 8 percent. It appears that this change is recommended based on mathematics without regard for the acuity of the patients. **LTCHs would only receive these payments if the patient exceeded the outlier threshold, at significant cost to the LTCH.** To propose an adjustment in the threshold will further increase the LTCH loss on each of these patients before the case qualifies as a high-cost outlier.

If the CMS deems an increase in the outlier threshold is warranted, the Spectrum Health Special Care Hospital recommends raising the outlier threshold at the same rate as the annual update factor.

Respectfully submitted,

Don Romain
CEO and Administrator
Spectrum Health Special Care Hospital

Submitter : Dr. Stacey Hinderliter **Date:** 03/26/2007

Organization : Lynchburg Family Medicine Residency Program

Category : Physician

Issue Areas/Comments

Background

Background

I am a pediatrician who is now a full time faculy member of Lynchburg Family Medicine Residency Program since 10/06. However, for the past 10 years, I have served as part-time preceptor for these same Family Medicine residents through my work at the local health department.

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

By definition, education in Family Medicine involves putting the residents in the learning atmosphere in which they will acqire the skills necessary to care for the whole patient from birth to the end of life. The majority of these skills are learned in out-patient settings and are taught by part-time preceptors. Family Medicine residents must learn how to manage out-patient problems since this their practice will involve a majority of out-patient care. Restricting the payment for their education to inpatient experiences does not recognize the importance of a well-rounded education to their clinical skills. One can not learn about well child care, immunizations, child development, etc. in an inpatient setting. Neither can one learn how to manage prenatal care and adult chronic disease in a strictly inpatient setting.

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

Restricting Family Medicine residents to inpatient rotations will significantly impact their ability to learn their specialty.

Submitter : **Dr. Ted Schaffer** **Date: 03/26/2007**

Organization : **UPMC St. Margaret family Medicine Residency**

Category : **Physician**

Issue Areas/Comments

Background

Background

UPMC St. Margaret Residency Porgram houses a large family medicine residency, with 50 housestaff in training. We have trained almost 450 physicians now spread throughout the nation, providing care in a number of areas including rural and underserved urban regions. We rely on volunteer outside community physicians to provide much of our residents' ambulatory experience, especially in specialty areas such as dermatology, neurology, urology, etc. The system has worked well for many years, and we have absorbed all the costs of educating these residents.

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

Monitoring the volunteer activities of community physicians, and providing all the calculations necessary to verify what occurs will be an accounting nightmare for our institution. Furthermore, we fear that some of our volunteer physicians will decline to educate our residents, thus severely impairing needed outpatient training for our residents.

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

As stated above, implementation of the CMS proposal could have severe adverse consequences for the education of our family medicine residents. The potential negative educational consequences actually far exceed the financial impact.

Submitter : Mr. Gregg Redfield **Date:** 03/26/2007

Organization : Minnesota Hospital Association

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

LTC-DRG Classifications and Relative Weights

LTC-DRG Classifications and Relative Weights

See Attachment

Other Proposed Policy Changes For The 2008 LTCh PPS Rate

Other Proposed Policy Changes For The 2008 LTCh PPS Rate

See Attachment

CMS-1529-P-96-Attach-1.PDF

#96

Minnesota Hospital Association

2550 University Ave. W., Suite 350-S
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toll-free: (800) 462-5393; www.mnhospitals.org

March 26, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: (CMS–1529–P) Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes, (Vol. 72, No. 21), February 1, 2007

Dear Ms. Norwalk:

On behalf of the Minnesota Hospitals Association's (MHA) 131 member hospitals and health care organizations, we appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed changes to the long-term care hospital (LTCH) prospective payment system (PPS). We are troubled by CMS' proposed expansion of the 25% Rule on patient referral source, changes to the short-stay outlier policy and an offset for coding changes. However, we support the move to re-weight the LTCH diagnosis-related groups (DRGs) in a budget-neutral manner.

EXPANSION OF THE 25% RULE TO FREESTANDING AND GRANDFATHERED LTCHS

In its fiscal year (FY) 2005 rule, CMS implemented payment limitations for LTCHs that are co-located with other hospitals in response to concerns about "inappropriate patient shifting" between acute care hospitals and LTCHs. Under the rule, when an LTCH is co-located with another hospital, no more that 25 percent of the LTCH's admissions from the co-located hospital will be paid at the full LTCH prospective payment rate. If the LTCH receives more than 25 percent of its admissions from the co-located hospital, the LTCH payments will be reduced for those patients exceeding the limit. CMS adopted the 25% Rule, in part, to address its concern that locating an LTCH within an acute care hospital might encourage the shifting of patients from host hospitals to co-located LTCHs for financial – rather than medically appropriate – reasons.

As part of its annual LTCH PPS payment update for 2008, CMS proposes to extend the 25% Rule to all LTCHs, including freestanding and satellite facilities, as well as LTCHs that were exempted from the original 25% Rule. To accommodate LTCHs located in rural areas or in metropolitan statistical areas (MSAs) served by one or more "MSA dominant hospitals" (i.e., hospitals that generate more than 25 percent of the Medicare discharges in the MSA), the agency increases the referral limitation to 50 percent. However, this move falls short of addressing the unique needs of most LTCHs and the general acute care hospitals that rely on them as part of their community's health care continuum.

As with the existing 25% Rule application, CMS' proposed expansion to all LTCHs lacks any meaningful relationship to the clinical appropriateness of LTCH admissions. LTCHs provide intense care to patients who require longer lengths of stay than a typical patient in an inpatient hospital, such as those on ventilators or burn victims. Any proposed policy regarding LTCHs should ensure access for patients for whom LTCH care is medically appropriate– a view supported by the Medicare Payment Advisory Commission. CMS is making payment decisions based on an arbitrary percentage. Last year, CMS released a report by the Research Triangle Institute (RTI) that identified feasible patient and facility criteria that would help distinguish LTCHs from other acute care facilities. However, CMS has not yet used the report to produce specific policy recommendations.

Rather than limiting access to LTCH services through payment cuts, we urge CMS not to move forward with the proposed rule, but to work with the RTI and LTCH providers to develop appropriate facility and patient-centered criteria to determine the types of patients that should be treated in LTCHs.

SHORT-STAY OUTLIERS

The LTCH short-stay outlier policy applies to cases with a length of stay up to 5/6 of the geometric mean length of stay for a particular diagnosis. In rate year (RY) 2007, CMS modified the LTCH short-stay outlier policy by adding the fourth payment alternative described below; as a result, Medicare payments to LTCHs were reduced by an estimated $156 million. Currently, short-stay outlier cases are paid the lesser of four payment alternatives:

- 100 percent of patient costs;
- 120 percent of the per diem of the LTCH DRG payment;
- the full LTCH DRG payment; or
- a blend of the general hospital inpatient PPS per diem and 120 percent of the LTCH PPS per diem. As a patient's length of stay increases, the LTCH DRG portion of the blend increases.

CMS' analysis of FY 2005 MedPAR data shows that 42 percent of LTCH short-stay outlier cases had lengths of stay that were less than or equal to the comparable length of stay (plus one standard deviation) for general acute care hospitals. Further data analysis shows that for

ventilator and ventilator/tracheotomy patients, the number of post-intensive care days in the general acute care hospital drop significantly if the patient is discharged to an LTCH – 42 percent and 77 percent, respectively. From these analyses, CMS concludes that for cases with a length of stay equal to or less than the comparable general acute hospital stay, a full LTCH payment is inappropriate. The RTI included this proposal in its report to CMS last year.

LTCH patient severity and costs are very different from general acute care patients and validate the need for a separate LTCH payment. Concerns about early discharge from the general acute setting and "double" payment for LTCH cases are already addressed by use of the post-acute care transfer provision that reduces the PPS payment to general acute hospitals that discharge patients to an LTCH. The current short-stay outlier policy significantly reduces payments to LTCHs. Additional changes to further cut LTCH payment are unnecessary. **We urge CMS to omit its proposed short-stay outlier policy from the final rule.**

INFLATIONARY UPDATE AND BEHAVIORAL OFFSET FOR CODING CHANGES

For RY 2008, CMS forecasts a LTCH PPS market basket of 3.2 percent based on the rehabilitation, psychiatric and long-term care market basket. Unlike most Medicare payment systems, federal statute does not require CMS to annually apply a full market basket update to the LTCH PPS. In fact, CMS proposes to partially offset the 3.2 percent market basket update with a coding adjustment of negative 2.49 percent, intended to account for coding increases in FY 2005.

For 2005, CMS calculated a *total* case mix index increase of 3.49 percent, which the agency believes is partially due to coding behavior, called "*apparent* case mix," and partially due to the increased cost of treating more resource intensive patients, called "*real* case mix." CMS based its projected growth in real case mix of 1.0 percent on experience and patterns in the general acute inpatient PPS. Therefore, for RY 2008, CMS is recommending a coding adjustment of negative 2.49 percent that reflects CMS' estimates of *total* case mix index increase minus *real* case mix index increase in FY 2005 (3.49 – 1.0 = 2.49). With the agency's proposed negative 2.49 percent coding adjustment, the actual RY 2008 update would be only 0.71 percent.

CMS should use the full market basket index projection for updating LTCH payments – the 2.49 percent downward adjustment is unwarranted. CMS' policies over the last two years have reduced LTCH payments by more than 7 percent. With hospital input costs increasing significantly due to inflation, a full market basket update is warranted.

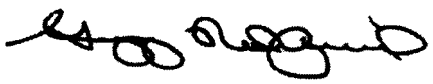
BUDGET-NEUTRAL RE-WEIGHTING OF THE LTCH DRGS

As the sole exception under Medicare, the LTCH DRGs may be re-weighted in a non-budget-neutral manner – a method that CMS utilized in RY 2007 to reduce Medicare payments to LTCHs. LTCH DRG re-weighting coincides with the annual re-weighting of the DRGs for general acute care hospitals, and takes effect each October 1. It captures changes in the relative

cost of treating patients in each of the 538 LTCH DRGs, such as treatment patterns, technology and number of discharges per DRG. In the proposed rule, CMS recommends that the annual re-weighting of the LTCH DRG be conducted on a budget-neutral basis, beginning October 1, 2007. This provision would be included in the FY 2008 proposed and final rules for the inpatient PPS. The agency is proposing this change since analysis of claims from FYs 2003 through 2005 indicates that LTCH coding practices have stabilized, and therefore, the most recent case mix increases are primarily due to higher patient severity rather than coding behavior, which had been identified as the primary cause in prior years. **MHA supports re-weighting the LTCH DRGs in a budget-neutral manner and urges CMS to move forward with this proposal.**

Please feel free to contact me with any questions or concerns.

Sincerely,



Gregg Redfield, CMA
Vice President, Finance
(651) 603-3536
gredfield@mnhospitals.org

Submitter : **Dr. Antonio Pedroza** **Date: 03/26/2007**

Organization : **Valley Family Medicine Residency**

Category : **Academic**

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

I am the family medicine residency director at Valley Family Medicine at the Valley Medical Center in Renton, Washington. I are writing to adamantly oppose this proposal: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes.

Family medicine training in our region regularly occurs in the community. We rely heavily on preceptors in the community to help train residents to be the kind of doctors that are needed in the largely rural areas of these five states in the Northwest.

Here are six critical points that I would like to make clear in for my argument against this proposal:

1. I appreciate CMS's effort to define "All Substantially All" to a threshold of 90 %. However that threshold is still too high and needs to be reduced to 75 %.

2. CMS should allow for physician volunteerism that most if not all of our community physicians provide.

3. CMS should allow programs / hospitals to exclude the costs of teaching physicians as part of the definition of "all or substantially all".

4. I recommend the 3 hour of non clinical didactic time be dropped to 1 hour per week as this most closely fits with the reality of this time in community preceptor s offices. If the 3 hour non-clinical didactic per week rule is used then that should be prorated for the number of clinics that the residents have with the preceptor per week (for example many of our residents come back to the residency for their weekly clinics).

5. Hospitals / programs that are over their cap on residency slots as determined by BBA or BBRA have no duty to fulfill the requirements of this rule as the Medicare program is not paying for such training.

6. CMS has and will continue to adversely affect Family Medicine programs ability to train Family Physicians in community programs by having overly burdensome and onerous requirements for the use of community preceptors, none of whom see this as a problem.

In summary, the proposed policy would make training in the community difficult or impossible for most of our programs. This negative result is the opposite of what is needed to train family physicians for community practice.

Sincerely,

Antonio Pedroza, MD
Residency Program Director
Valley Family Medicine Residency
Valley Medical Center
3915 Talbot Road South, Suite 401
Renton, Washington 98005
Telephone: 425-656-4126

Submitter : **Dr. David Smith** **Date: 03/26/2007**

Organization : **North Colorado Family Medicine Residency Program**

Category : **Physician**

Issue Areas/Comments

Background

Background

I am a faculty family physician in our family medicine residency program here in Greely, CO. I am the coordinator for our curriculum.

GENERAL

GENERAL

This proposal would be very difficult for us to implement. A great deal of our resident physicians' training occurs outside of the hospital, usually in community physician's offices. We use 4 outside preceptors in our residency clinic. Outpatient rotations include: Orthopedics, Pediatrics, GYN, Cardiology, Urology, Rural rotations, Surgery, Pulmonology, ENT, Ophthalmology, Derm and several electives. There is quite a variety as to office locations for these many different rotations. About 50% of our extensive didactic curriculum occurs in the outpt setting. Though we have 7 faculty physicians to train our resident physicians, we rely heavily on approximately 100 other community physicians to train them on a volunteer basis. Our sponsoring hospital already loses quite a huge amount of money on our program. Decreasing their IME/DME payments would greatly jeopardize their continuing sponsorship of our program, which, by the way, places the vast majority of our graduates in very rural locations, where the need is greatest.

Submitter : **Ms. Katherine Stephens** **Date: 03/26/2007**

Organization : **Palmetto Health**

Category : **Academic**

Issue Areas/Comments

GENERAL

GENERAL

We ask that consideration be given to the following attachment prior to promulgating final rules.

CMS-1529-P-99-Attach-1.DOC

#99

March 26, 2007

Leslie V. Norwalk, Esq, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P. O. Box 8015
Baltimore, Maryland 21244-8015

Reference: file code CMS-1529-P

Dear Ms. Norwalk,

This letter is to respond to your request for comments on Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes as published in the February 1, 2007 Federal Register. We ask that consideration be given to the following comments prior to promulgating final rules.

Under the proposed rules, we understand that physician supervisory costs will be calculated using a week long basis – regardless of the amount of time that a resident actually is in the non-hospital site. Resident time, however, will be calculated using FTE counts. We ask that this calculation be changed to count both physician and resident time based on FTEs. Some of our residents who rotate in non-hospital sites are in those locations ½ day per week over a year's period. Using the proposed formula would require a disproportionately large payment to these supervising physicians. Adjusting the rotation time to provide the same total amount of time in fewer weeks would not allow for patient continuity to occur over the year and would decrease the educational quality of the rotations.

We also ask that the percentage of reimbursable physician hours be capped at 7 ½%, which is equivalent to 3 hours in a 40 hour week. Because some surgical non-hospital sites have fewer than 40 hours open each week, but spend a large amount of time in hospital operating rooms, it would be unreasonable to calculate physician supervisory costs based on their posted office hours.

We ask that changes be made to allow physicians to complete documentation attesting to the number of hours spent in non-billable supervisory activities or alternately, to allow institutions to perform time studies one period (month) every three years and use this calculation to determine the number of hours payable for physician supervisory costs.

Finally, we ask that changes be made to allow institutions and medical schools to make final adjustments to its master schedule for rotations at the end of each academic year – much in the way that current aggregate reconciliations are made for resident FTE caps. Changes in rotation schedules are made during the year, and a reconciliation at the end of the academic year would allow greater accuracy.

Thank you for your consideration of these requested adjustments in the final rules.

Cordially,

Katherine G. Stephens

Katherine G. Stephens, MBA, FACHE
Vice President, Medical Education
Palmetto Health
5 Richland Medical Park
Columbia, South Carolina 29203

Submitter : Mr. Steven C. Glass **Date:** 03/26/2007

Organization : Cleveland Clinic

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1529-P-100-Attach-1.PDF

#100

Cleveland Clinic

Steven C. Glass
Chief Financial Officer

March 26, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244

RE: CMS-1529-P

Cleveland Clinic, a not-for-profit multi-specialty academic medical center that integrates clinical and hospital care with research and education, is pleased to have the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule dealing with matters governing resident training in non-hospital settings. We appreciate the effort CMS has made to make its policy easier to administer than is the case under current circumstances.

We have but a few observations to offer:

1. Over the last decade the area of graduate medical education has become a maze of regulation and instruction that increasingly requires additional non-teaching resources just to maintain appropriate records. The extension of the "all or substantially all" requirement into non-hospital settings where the tradition has been one of voluntary participation causes uncertainty and disruption in the field and undercuts the teaching mission. If CMS feels it is necessary to continue its policy interpretation, we would urge that it listen carefully to comment from the field and find ways to significantly reduce scope and burden rather than just address it marginally.

2. The "all or substantially all" standard—The NPRM proposes to drop this standard from 100% to 90%. While moving in the right direction, we believe that the modification still sets the bar too high. There is no way to define what is the right level, but we would think it would be more reasonable to set it closer to 60% or 70%, which then does allow more flexibility at the local level.

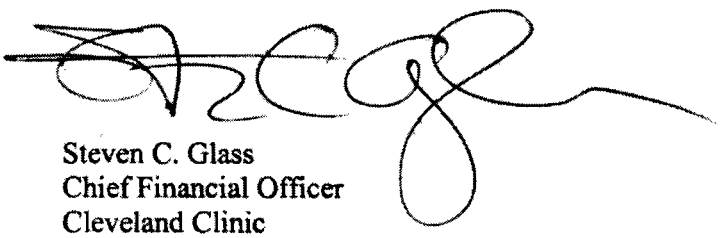
The Cleveland Clinic Foundation
9500 Euclid Avenue / H18
Cleveland, Ohio 44195
Tel 216 444-2575
Fax 216 445-8985
glasss@ccf.org

3. The type of physician organization to which the rule would apply—While it is neat and logical from Baltimore to distinguish by salary versus income practice; it is not that neat in the field. At Cleveland Clinic we have salaried physicians, some who spend some of their time as teaching physicians and some who do not. All are salaried, but there is no explicit add-on for the physician engaged in teaching nor is there a reduction for the physician who is not. It is these types of presumptions that make a policy of this nature particularly arbitrary in its application, and it is an argument for minimizing the impact of this policy. The same points are true related to the estimate of how much time a physician spends in supervision of residents. Neat from Baltimore; arbitrary in the field.

4. The written agreement—The written agreement has come to symbolize the difficulty in administration of the myriad of policies CMS has issued over the past decade, and it has become increasingly difficult to maintain compliance without a bevy of analysts and lawyers to be sure that absolutely every facet of GME is addressed. Adding this detail without also reviewing the various written agreement requirements makes the agreement still more complex. Instead of simply tacking on yet another set of requirements, we would urge CMS to institute a review of the written agreement with a view toward simplification.

Thank you for your consideration and the opportunity to comment.

Sincerely,



Steven C. Glass
Chief Financial Officer
Cleveland Clinic

Submitter : **Patricia Andersen** **Date: 03/26/2007**

Organization : **Oklahoma Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See two attached letters. One letter provides comments relating to the proposed rule to update LTCH PPS and the second letter provides comments regarding the proposed change to Graduate Medical Education.

CMS-1529-P-101-Attach-1.DOC

CMS-1529-P-101-Attach-2.DOC

#101

Oklahoma Hospital Association

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(405) 427-9537
www.okoha.com

Craig W. Jones, FACHE
President

March 26, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: (CMS–1529–P) Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes, (Vol. 72, No. 21), February 1, 2007

Dear Ms. Norwalk:

On behalf of our near 150 member hospitals, health systems and other health care organizations, the Oklahoma Hospital Association (OHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed changes to the long-term care hospital (LTCH) prospective payment system (PPS). We are very concerned about CMS' proposed expansion of the 25% Rule on patient referral source, changes to the short-stay outlier policy and an offset for coding changes. We are, however, supportive of the move to re-weight the LTCH diagnosis-related groups (DRGs) in a budget-neutral manner.

EXPANSION OF THE 25% RULE TO FREESTANDING AND GRANDFATHERED LTCHS

In its fiscal year (FY) 2005 rule, CMS implemented payment limitations for LTCHs that are co-located with other hospitals in response to concerns about "inappropriate patient shifting" between acute care hospitals and LTCHs. Under the rule, when an LTCH is co-located with another hospital, no more that 25 percent of the LTCH's admissions from the host hospital will be paid at the full LTCH prospective payment rate. If the LTCH receives more than 25 percent of its admissions from the host hospital, the LTCH payments will be reduced for those patients admitted to the LTCH from the host hospital exceeding the limit. CMS adopted the 25% Rule, in part, to address its concern that

locating an LTCH within an acute care hospital might encourage the shifting of patients from host hospitals to co-located LTCHs for financial – rather than medically appropriate – reasons. As part of its annual LTCH PPS payment update for 2008, CMS proposes to extend the 25% Rule to all LTCHs, including freestanding and satellite facilities, as well as LTCHs that were exempted from the original 25% Rule. To accommodate LTCHs located in rural areas or in metropolitan statistical areas (MSAs) served by one or more "MSA dominant hospitals" (i.e., hospitals that generate more than 25 percent of the Medicare discharges in the MSA), the agency increases the referral limitation to 50 percent. However, this move falls short of addressing the unique needs of most LTCHs and the general acute care hospitals that rely on them as part of the health care continuum for their communities.

As with the existing 25% Rule application, CMS' proposed expansion to all LTCHs appears to be arbitrary and lacks any meaningful relationship to the clinical appropriateness of LTCH admissions. LTCHs provide intense care to patients who require longer lengths of stay than a typical patient in an inpatient hospital, such as those on ventilators or burn victims. Any proposed policy regarding LTCHs should ensure access for patients for whom LTCH care is medically appropriate– a view supported by the Medicare Payment Advisory Commission. Last year, CMS released a report by the Research Triangle Institute (RTI) that identified feasible patient and facility criteria that would help distinguish LTCHs from other acute care facilities. To date, CMS has not used the report to produce specific related policy recommendations.

Rather than limiting access to LTCH services through payment cuts, we urge CMS not to move forward with the proposed rule, but rather to work with the RTI and LTCH providers to develop appropriate facility and patient-centered criteria to determine the types of patients that should be appropriately treated in LTCHs.

SHORT-STAY OUTLIERS

The LTCH short-stay outlier policy applies to cases with a length of stay up to 5/6 of the geometric mean length of stay for a particular diagnosis. In rate year (RY) 2007, CMS modified the LTCH short-stay outlier policy by adding the fourth payment alternative described below; as a result, Medicare payments to LTCHs were reduced by an estimated $156 million. Currently, short-stay outlier cases are paid the lesser of four payment alternatives:

- 100 percent of patient costs;
- 120 percent of the per diem of the LTCH DRG payment;
- the full LTCH DRG payment; or
- a blend of the general hospital inpatient PPS per diem and 120 percent of the LTCH PPS per diem. As a patient's length of stay increases, the LTCH DRG portion of the blend increases.

CMS' analysis of FY 2005 MedPAR data shows that 42 percent of LTCH short-stay outlier cases had lengths of stay that were less than or equal to the comparable length of stay (plus one standard deviation) for general acute care hospitals. Further data analysis shows that for ventilator and ventilator/tracheotomy patients, the number of post-intensive care days in the general acute care hospital drop significantly if the patient is discharged to an LTCH – 42 percent and 77 percent, respectively. From these analyses, CMS concludes that for cases with a length of stay equal to or less than the comparable general acute hospital stay, a full LTCH payment is inappropriate. The RTI included this proposal in its report to CMS last year.

LTCH patient severity and costs are very different from general acute care patients and validate the need for a separate LTCH payment. Concerns about early discharge from the general acute setting and "double" payment for LTCH cases are already addressed by use of the post-acute care transfer provision that reduces the PPS payment to general acute hospitals that discharge patients to an LTCH. The current short-stay outlier policy significantly reduces payments to LTCHs. Additional changes to further cut LTCH payment are unnecessary.

We urge CMS to omit its proposed short-stay outlier policy from the final rule.

INFLATIONARY UPDATE AND BEHAVIORAL OFFSET FOR CODING CHANGES

For RY 2008, CMS forecasts a LTCH PPS market basket of 3.2 percent based on the rehabilitation, psychiatric and long-term care market basket. Unlike most Medicare payment systems, federal statute does not require CMS to annually apply a full market basket update to the LTCH PPS. In fact, CMS proposes to partially offset the 3.2 percent market basket update with a coding adjustment of negative 2.49 percent, intended to account for coding increases in FY 2005.

For 2005, CMS calculated a *total* case mix index increase of 3.49 percent, which the agency believes is partially due to coding behavior, called "*apparent* case mix," and partially due to the increased cost of treating more resource intensive patients, called "*real* case mix." CMS based its projected growth in real case mix of 1.0 percent on experience and patterns in the general acute inpatient PPS. Therefore, for RY 2008, CMS is recommending a coding adjustment of negative 2.49 percent that reflects CMS' estimates of *total* case mix index increase minus *real* case mix index increase in FY 2005 (3.49 – 1.0 = 2.49). With the agency's proposed negative 2.49 percent coding adjustment, the actual RY 2008 update would be only 0.71 percent.

We encourage CMS to use the full market basket index projection for updating LTCH payments – the 2.49 percent downward adjustment is unwarranted. CMS' policies over the last two years have reduced LTCH payments by more than 7 percent. With hospital input costs increasing significantly due to inflation, a full market basket update is warranted.

BUDGET-NEUTRAL RE-WEIGHTING OF THE LTCH DRGS

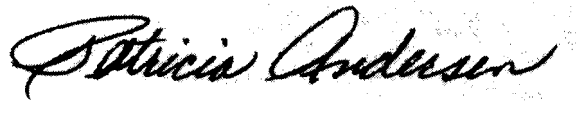
As the sole exception under Medicare, the LTCH DRGs may be re-weighted in a non-budget-neutral manner – a method that CMS utilized in RY 2007 to reduce Medicare payments to LTCHs. LTCH DRG re-weighting coincides with the annual re-weighting of the DRGs for general acute care hospitals, and takes effect each October 1. It captures changes in the relative cost of treating patients in each of the 538 LTCH DRGs, such as treatment patterns, technology and number of discharges per DRG. In the proposed rule, CMS recommends that the annual re-weighting of the LTCH DRG be conducted on a budget-neutral basis, beginning October 1, 2007. This provision would be included in the FY 2008 proposed and final rules for the inpatient PPS. The agency is proposing this change since analysis of claims from FYs 2003 through 2005 indicates that LTCH coding practices have stabilized, and therefore, the most recent case mix increases are primarily due to higher patient severity rather than coding behavior, which had been identified as the primary cause in prior years.

The OHA supports re-weighting the LTCH DRGs in a budget-neutral manner and urges CMS to move forward with this proposal.

If you have any questions, please feel free to contact me at pandersen@okoha.com or (405) 427-9537.

Sincerely,

OKLAHOMA HOSPITAL ASSOCIATION



Patricia Andersen, CPA
CFO & VP Finance and Information Services

Submitter : Mr. William Walters **Date:** 03/26/2007

Organization : Acute Long Term Hospital Association

Category : Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment for ALTHA's supplemental comment letter.

CMS-1529-P-102-Attach-1.DOC

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ACUTE LONG TERM HOSPITAL ASSOCIATION

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March 26, 2007

BY ELECTRONIC FILING AND HAND DELIVERY

Hon. Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1529-P
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, D.C. 20201

Re: ***Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes; Proposed Rule, 72 Fed. Reg. 4776 (February 1, 2007)***

SUPPLEMENTAL COMMENT LETTER

Dear Ms. Norwalk:

This letter presents supplemental comments of the Acute Long Term Hospital Association ("ALTHA") to certain aspects of the proposed annual payment rate updates and policy changes under the prospective payment system for long-term acute care hospitals ("LTACH PPS") for rate year ("RY") 2008, which were published by the Centers for Medicare & Medicaid Services ("CMS") on February 1, 2007. Please refer to our comment letter dated March 23, 2007 for ALTHA's main set of comments to the proposed rule. This supplemental letter responds to recent data shared by CMS with ALTHA representatives.

CMS proposes to impose an arbitrary cap (25%) on the percentage of patients that freestanding LTACHs can admit from any primary referral source without suffering a payment penalty. In addition, CMS proposes to impose a payment penalty on cases that CMS characterizes as "very short stay." The primary justification offered by CMS for both of these policies is the unverified concern that short term acute care hospitals ("STACHs") are discharging patients to LTACHs "early" before completing their full "episode of care" in the STACH such that Medicare would be paying twice for the same episode of care. As set forth in detail in ALTHA's comments, publicly available data actually contradict CMS's assertion, for the following reasons:

- CMS's own research contractor concluded that the issue of whether STACHs and LTACHs are "substitutes" such that Medicare may be paying twice for a single episode of care is "poorly understood" and more research is needed before conclusions can be drawn;

- MedPAR data show there is very little overlap in the DRGs (diagnostic codes) assigned to patients when they leave STACHs and the DRGs assigned to the same patients when they leave LTACHs. For Medicare payment purposes the "episode of care" is defined by the DRG and Medicare could be paying twice for the same episode only if the same patients are assigned the same DRGs;

- No evidence exists to support the concern that STACHs are discharging patients "early" to LTACHs in order to maximize DRG payments. On the contrary, MedPAR data show that the vast majority of patients are discharged to LTACHs after staying in STACHs nearly twice as long as the average hospital patient. Moreover, nearly all of the DRGs (83%) that apply to short-term hospital discharges to LTACHs are already subject to reduced payment under Medicare's "post-acute transfer" payment policy, so the issue of "early discharge" is already addressed by CMS regulations;

- No evidence exists that STACHs are discharging patients "early" to LTACHs in order to avoid losses under the "high cost outlier" payment policy. Although CMS asserts that this is their primary concern and justification for the proposed policies, the data show the opposite: as the percentage of STACH discharges to LTACHs increases, the percentage of STACH high cost outlier cases also increases. This definitively contradicts CMS's purported rationale for the proposed rule and CMS does not offer any data to the contrary.

- LTACH patients, even shorter stay patients, are much more severely ill and expensive to care for than average STACH patients, so CMS's proposal to pay LTACHs using STACH rates is fundamentally flawed.

In meetings between CMS and ALTHA representatives, CMS indicated that their primary concern is STACHs discharging patients to LTACHs "early" to avoid high cost outlier status. CMS referred to data indicating a "precipitous" drop in STACH high cost outlier cases when patients are sent to LTACHs. ALTHA requested and CMS provided a summary of this data. This letter responds to that data.

The data referred to by CMS to support their concern that STACHs are inappropriately avoiding high cost outlier cases by discharging patients to LTACHs early is not specifically discussed in the rulemaking record. ALTHA believes it is inappropriate and contrary to the Administrative Procedure Act for CMS to rely on this justification or data without including it in the rulemaking record for the specific proposal to extend the 25% rule to freestanding LTACHs or to make further changes to the SSO payment policy. In any event, the data CMS relies on does not support its stated concern.

Specifically, CMS points to the following discussion to support its belief that STACHs are discharging patients to *freestanding* LTACHs "early," prior to completing episodes of care, to avoid high cost outlier status:

> In analyzing the discharge data, we have looked at data from 1996 through 2003 from our MedPAR files, focusing our data analyses on changes in lengths of stay that exceed the geometric mean cases at host hospitals that are co-located with LTCH HwHs or LTCH satellites as opposed to those without LTCH HwHs or LTCH satellites. Our concern is that, in general, a significant volume of these cases are being discharged to the onsite LTCH prior to reaching outlier status. We compared the number of Medicare covered days for specific DRGs with data from hospitals before and after they became a host hospital. We selected DRGs that MedPAC had identified as being more likely to lead to cases in which a host hospital would transfer the patient from the acute care hospital to their co-located long-term acute care facility.

> Acute hospitals were grouped into cohorts for each year from 1996 through 2003: those that were freestanding as distinct from those that currently were hosting a long-term care hospital. For all but one DRG (482), the mean amount of covered days across all years for hospitals that were currently hosting a LTCH was lower in comparison to when they were not hosting a LTCH. Four DRGs (263, 265, 266 and 483) experienced decreases over ten percent. We also looked at covered days for DRGs 483, 126, 264, and 475 for the year 1999 (since all the acute care hospitals in the analysis were not hosting LTCH HwHs or LTCH satellites that year) in comparison to 2002 and 2003 (because all the acute care hospitals in the analysis were hosting LTCH HwHs or LTCH satellites in those years). For most of these DRGs (particularly DRG 483), the number of discharges with a very high number of Medicare days decreases quite significantly at the acute care hospital after it became a host. We believe that this data indicates a correlation between the presence of a LTCH as a LTCH HwH or a LTCH satellite within an acute care hospital and a shorter length of stay for Medicare beneficiaries at the acute care hospital.

69 Fed. Reg. 48,916, 49,201 (August 11, 2004).

These data do not support CMS's contention that freestanding LTACHs are acting as units of STACHs so as to reduce the number of high cost outlier cases experienced by STACHs:

- The CMS data refers to analysis conducted on hospital-within-hospital ("HwH") LTACHs, not freestanding LTACHs. It would be arbitrary and capricious for CMS to use data wholly inapplicable to freestanding LTACHs to justify a dramatic change in policy;

- CMS relies on old data, from 1996-2003, which is not relevant to current referral patterns, lengths of stay, or the relationship between STACH and LTACH hospitals. First, using old data ignores the numerous policy changes, including the phased-in implementation of the HwH 25% rule, that have intervened since the analysis was done. CMS cannot make any assumptions about the applicability of this old data to current referral patterns without accounting for these changes in policy. As noted in ALTHA's primary comments, the 25% HwH rule has not even been fully implemented. Second, as CMS well knows, the geometric means upon which the old data relies change every year as part of the DRG re-weighting process and recalibrating the high cost outlier thresholds. Accordingly, lengths of stay and referral patterns as it relates to the frequency or decline in high cost outlier cases changes from year to year and it is statistically invalid to draw conclusions about changes in lengths of stay relative to DRG thresholds from one year to the next;

- Most important, the analysis relied upon by CMS does not even prove the point they are trying to make, namely, that there is a relationship between LTACH utilization and the percentage of cases that become high cost outliers. Instead, the analysis picks a limited number of DRGs and purports to show a decrease in the number of covered Medicare days spent in an STACH past the geometric mean when HwH LTACHs are present. As shown below, an analysis of all DRGs shows that LTACH utilization is actually associated with an increase—not a decrease—in the percentage of high cost outlier cases experienced by STACHs. Moreover, the CMS analysis is flawed by measuring a change in the number of Medicare covered days rather than the actual percentage of cases receiving high cost outlier payments. As described in detail in ALTHA's primary comments, for one primary DRG relied upon by CMS (DRG 483, Ventilator-Trach patients), the decrease in the number of Medicare days observed by CMS is due to the fact that the majority of these patients are discharged "early," well before the DRG threshold. This "early" discharge results in a reduced Medicare payment below the full DRG amount because this DRG is subject to Medicare's post acute transfer policy

payment reduction. Accordingly, the decrease in Medicare days observed by CMS can actually result in lower, not higher, Medicare costs.

As set forth in detail in ALTHA's primary comments, an objective analysis of CMS's own data from MedPAR 2005 flatly contradicts CMS's assumption: there is no relationship between the percent of high cost outlier cases in STACHs and the percent of discharges to LTACs. If anything, the data show the opposite, i.e., as the percentage of STACH discharges to LTACs increases, the percentage of high cost outliers in STACHs also increases slightly. The same pattern holds if the percentage of Medicare reimbursement spent on high cost outliers is used rather than the percentage of high cost outliers. Accordingly, ALTHA believes it would be arbitrary and capricious for CMS to expand the 25% rule to freestanding LTACHs or make further adjustments to the short stay outlier policy when publicly available data not only do not support CMS's position, data actually contradicts CMS's position.

ALTHA urges CMS to withdraw and reconsider its proposed LTACH rule in light of compelling data indicating that CMS's policy justifications for the proposed rule are not supported by their own data. Instead, ALTHA urges CMS to heed the comments of MedPAC. Specifically, MedPAC's March 22, 2007 comments on the LTACH proposed rule caution CMS against approaches such as the "25% rule" because they can be "arbitrary and increase the risk of unintended consequences." Instead, MedPAC, like ALTHA, urges CMS to work with provider associations "to develop [LTACH certification] criteria" as the preferable policy route to address LTACH policy issues. ALTHA is ready and willing to work with CMS on patient and facility criteria for LTACHs. The LTACH certification criteria proposed by the Senate (S. 338) and the House of Representative (H.R. 562), which ALTHA supports, provide a basis for such collaboration.

Sincerely,

William Walters
Chief Executive Officer

Submitter : **Mr. Frank Battafarano** **Date: 03/26/2007**

Organization : **Kindred Healthcare**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1529-P-103-Attach-1.DOC

#103

Kindred Healthcare

March 26, 2007

BY ELECTRONIC FILING

Hon. Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1529-P
Mail Stop C4-26-5
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Baltimore, MD 21244-1850

Re: ***Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes; Proposed Rule, 72 Fed. Reg. 4776 (February 1, 2007)***

Dear Ms. Norwalk:

This letter presents the comments and recommendations of Kindred Healthcare, Inc. ("Kindred") to certain aspects of the proposed annual payment rate updates and policy changes under the prospective payment system for long-term acute care hospitals ("LTACH PPS") for rate year ("RY") 2008, which were published by the Centers for Medicare & Medicaid Services ("CMS") on February 1, 2007.

Kindred Healthcare is one of the nation's largest providers of LTACH services, with 63 freestanding LTACHs, eighteen hospital within hospital LTACHs and 6,419 beds. In 2006, Kindred provided care to over 28,000 Medicare beneficiaries. As a long-term acute care hospital provider, Kindred provides specialized acute care for medically complex patients who are critically ill with multi-system complications and require hospitalization averaging at least 25 days. Many of Kindred's patients—including Medicare beneficiaries—are admitted directly from short-stay hospital intensive care units with respiratory/ventilator-dependent conditions or other complex medical conditions. At Kindred's LTCHs, they receive a specialized treatment program with aggressive clinical and therapeutic intervention. The proposed policies and reimbursement changes in the proposed rule will have a direct, adverse impact on the LTACHs operated by Kindred.

Kindred opposes the reductions in long-term care hospital ("LTACH") payments that will result if the proposed changes to the LTACH PPS are implemented. Over the past few years, CMS has implemented numerous payment cuts and regulatory changes because of the concern that the number of LTACHs was growing too rapidly and Medicare margins were too high. The cumulative effect of CMS policy is that these two policy concerns have been addressed: CMS's own data shows that LTACH growth has slowed to a standstill and, according to MedPAC, Medicare margins are now close to zero. The proposed payment changes, if finalized, would bring Medicare payments for LTACHs well below cost, threatening the vital care that Medicare's most vulnerable beneficiaries need.

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Not only does the proposed rule arbitrarily reduce LTACH payments below the cost of care, CMS's purported justifications for the changes lack merit and are contradicted by publicly available data. CMS proposes to impose an arbitrary cap (25%) on the percentage of patients that freestanding LTACHs can admit from any primary referral source without suffering a payment penalty. In addition, CMS proposes to impose a payment penalty on cases that CMS characterizes as "very short stay." The primary justification offered by CMS for both of these policies is the unverified concern that short term acute care hospitals are discharging patients to LTACHs "early" before completing their full "episode of care" in the Short Term Acute Care Hospital ("STACH") such that Medicare would be paying twice for the same episode of care. CMS offers no data whatsoever to support this concern. Publicly available data actually contradict CMS's assertion, for the following reasons:

- CMS's own research contractor concluded that the issue of whether acute hospitals and LTACHs are "substitutes" such that Medicare may be paying twice for a single episode of care is "poorly understood" and more research is needed before conclusions can be drawn;

- MedPAR data show there is very little overlap in the DRGs (diagnostic codes) assigned to patients when they leave acute care hospitals and the DRGs assigned to the same patients when they leave LTACHs. For Medicare payment purposes the "episode of care" is defined by the DRG and Medicare could be paying twice for the same episode only if the same patients are assigned the same DRGs;

- No evidence exists to support the concern that acute care hospitals are discharging patients "early" to LTACHs in order to maximize DRG payments. On the contrary, MedPAR data show that the vast majority of patients are discharged to LTACHs after staying in STACHs nearly twice as long as the average hospital patient. Moreover, nearly all of the DRGs (83%) that apply to short-term hospital discharges to LTACHs are already subject to reduced payment under Medicare's "post-acute transfer" payment policy, so the issue of "early discharge" is already addressed by CMS regulations;

- No evidence exists that acute care hospitals are discharging patients "early" to LTACHs in order to avoid losses under the "high cost outlier" payment policy. Although CMS asserts that this is their primary concern and justification for the proposed policies, the data show the opposite: as the percentage of short term acute care hospital discharges to LTACHs increases, the percentage of acute hospital high cost outlier cases also increases. This definitively contradicts CMS's purported rationale for the proposed rule and CMS does not offer any data to the contrary.

- LTACH patients, even shorter stay patients, are much more severely ill and expensive to care for than average STACH patients, so CMS's proposal to pay LTACHs using STACH rates is fundamentally flawed.

In short, CMS's proposed rule lacks any policy justification and is actually contradicted by publicly available data. Kindred urges CMS to reconsider its proposed changes to the LTACH PPS in light of the Medicare Payment Advisory Commission ("MedPAC") recommendations in June 2004 that the certification criteria for the Medicare LTACH provider category be strengthened to ensure that LTACH payments are being made to only those providers that are administering medically complex care to severely ill patients. Kindred supports this approach as a more defined method for limiting LTACH payments to hospitals that are truly caring for a medically complex patient population. Both the Senate and House of Representatives have introduced legislation to implement MedPAC recommendations, and Kindred urges CMS to support this proposed legislation rather than resort to blunt payment cuts to address policy issues for LTACHs. Certification criteria, not payment cuts, will advance policy for LTACHs and for all post-acute providers.

I. Discussion

A. Expansion of the "25% Rule" to Freestanding LTACHs

1. Summary of Proposal

In the IPPS final rule for fiscal year 2005, CMS established a special payment provision at section 412.534 for LTACHs that are HIHs and satellites of LTACHs. Under section 412.534, discharges from an HIH or satellite that were admitted from the co-located hospital that exceed 25% of the total Medicare discharges of the HIH or satellite during a single cost reporting period are paid at the lesser of the otherwise payable amount under LTACH PPS or the amount equivalent to what Medicare would otherwise pay under IPPS. HIHs and satellites located in rural areas and in Metropolitan Statistical Area ("MSA") dominant hospitals may discharge, during a single cost reporting period, up to 50% of the LTACH's total Medicare discharges from the co-located hospital before the HIH or satellite is subject to a payment adjustment. Patients on whose behalf a Medicare outlier payment was made at the referring hospital are not counted toward the 25% threshold, or applicable threshold for rural, urban-single, or MSA-dominant hospitals.

In the proposed rule, CMS would expand the payment limitation threshold to any LTACH or satellite of an LTACH that discharges during a single cost reporting period more than 25% (or applicable percentage for rural, single-urban, or MSA-dominant hospitals) of Medicare patients admitted from any non-co-located individual hospital. The proposed rule would apply to each individual hospital referral source to the LTACH and affect Medicare discharges from all LTACHs or LTACH satellites, regardless of whether the patient was admitted from a hospital located in the same building or on the same campus of the LTACH or satellite. CMS is also proposing a limited phase in of the expansion of the 25% rule.

CMS estimates that the expansion of the 25% rule will result in a 2.2% reduction in aggregate LTACH payments for RY 2008.

2. Kindred Response

a. CMS Proposes to Expand the Payment Limitation Threshold Before the Existing 25% Rule Is Fully Implemented and, Importantly, Before the Impact of the Existing 25% Rule Can Be Measured.

CMS's proposal to expand the payment limitation threshold to any LTACH or satellite of an LTACH is premature. The existing 25% rule became effective as recently as October 1, 2004 and has yet to be fully implemented. LTACHs existing on or before October 1, 2004 are not subject to the full impact of the 25% rule until their first cost reporting period beginning on or after October 1, 2007. During the transition period, CMS does not have the data required to confirm that the 25% rule is achieving the stated policy goals or, conversely, is having a dislocating effect in certain markets that result in access and quality problems. Without complete data, CMS cannot know whether the existing application of the 25% rule is achieving these goals without having adverse effects on patient care. For a credible analysis, CMS must examine the effect of the existing 25% rule at the conclusion of the transition period and postpone any further application of this rule. Specifically, CMS should allow more time to transpire before understanding the impact that the HwH 25% rule has had on LTACH growth. Publicly available data shows that even though the rule is not yet fully phased in, it is having a profound effect on LTACH growth. The number of Medicare certified LTACHs in 2006 decreased by one, as compared with 28 new LTACHs certified in 2005.

We continue to believe that the 25% rule is an ineffective method of ensuring the appropriateness of referrals from STACHs to LTACHs. CMS should focus its resources on enforcing its

existing requirements for HIHs at 42 C.F.R. § 412.22(e), and working with LTACHs and the Congress to implement comprehensive LTACH certification criteria, rather than take the premature step of expanding this payment penalty to freestanding LTACHs. Until the transition period for the HIH 25% rule is completed for all LTACH 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.

b. CMS Has Failed to Provide Credible Evidence to Support the Allegations that Medicare Is Paying Twice for the Same Episode of Care, or Freestanding LTACHs are Acting as Units of Referring Hospitals.

The proposal to expand the 25% rule to non-co-located LTACHs and grandfathered HIHs is based on CMS's assumption that all LTACHs are effectively acting as units of STACHs such that patients are not receiving a full episode of care at the STACH. In other words, CMS asserts that STACHs are discharging patients to LTACHs "early" prior to completing their episodes of care. The only evidence that CMS offers to support this assumption is the percentage of referrals that LTACs receive from primary referral sources. This data, taken alone, does not support the conclusion that Medicare is paying twice for a single episode of care and publicly available data actually contradict CMS's assumption.

(1) CMS's Own Research Contractor Concluded that Existing Data Do Not Support the Conclusion that Medicare Is Paying "Twice" for a Single Episode of Care.

CMS's primary rationale for expanding the 25% rule to freestanding LTACHs is the assumption that these providers effectively function as "units" of STACHs such that Medicare is paying "twice" for a single episode of care. Despite repeatedly citing this concern, CMS's own researchers have not found evidence that freestanding LTACHs are acting as units of STACHs. In 2004, CMS retained The Research Triangle Institute ("RTI") to study the feasibility of implementing MedPAC's recommendation to revise LTACH certification criteria. RTI specifically examined the extent to which STACHs and LTACHs serve as "substitutes" such that Medicare could be paying twice for a single episode of care. Based on their analysis to date, RTI concluded that this issue is "poorly understood."[1] In fact, RTI plans to examine this issue further in "Phase III" of its work for CMS. It is premature to draw any conclusions and entirely inappropriate for CMS to finalize such as a dramatic change in payment policy for LTACHs when its own contractor has concluded that CMS's purported rationale for the rule is "poorly understood" and not yet supported by data.

(2) There is no Evidence that Short Term Acute Care Hospitals are Discharging Patients to LTACs "Early," Prior to Completing Episodes of Care, to Maximize Profit.

There is no data to support a concern that STACHs are systematically discharging patients "early" to LTACs prior to completion of an episode of care in order to maximize profit or obtain a full DRG payment. On the contrary, MedPAR 2005 data show that the average length of stay for acute hospital patients eventually sent to LTACs is more than 4 days longer than the geometric mean length of stay for patients in the same DRGs (Figure 8, below). Among non-trach patients, representing almost 90% of all patients sent to LTACHs, the average length of stay for patients eventually sent to LTACs is nearly twice the geometric mean length of stay for all patients in the same DRGs (Figure 9, below). This indicates that the more medically complex patients typically sent to LTACs are staying in the acute hospital longer than the average patient and that acute hospitals are not systematically discharging

[1] See RTI Report, 2006, pgs. 54-55.

patients to LTACs early in order to maximize profits. The one exception to this pattern is for DRGs 541/542 (patients dependent on a ventilator who also received a tracheotomy). These patients are generally discharged earlier than the acute care hospital geometric mean length of stay (Figure 7, below). However, as discussed more fully below, payment for nearly 70% of these patients is less than a full DRG amount because payment is adjusted by the post acute transfer policy. It is very important to note that 83% of the DRGs applicable to acute hospital discharges to LTACs are subject to the post acute payment policy, so any concern that CMS might have about "early discharge" of patients by acute care hospitals to LTACs is already addressed by CMS payment policy. In any event, there is no evidence from the data that "early discharge" is occurring.

(3) There is no Evidence that Short Term Acute Care Hospitals are Discharging Patients to LTACs "Early," Prior to Completing Episodes of Care, to avoid High Cost Outlier Status.

Although not specifically discussed in the rulemaking record, informal conversations between Kindred and CMS revealed that another possible justification for the proposal to extend the 25% rule to freestanding LTACs is the concern that Short Term Hospitals may be discharging patients "early" to LTACs, prior to completing episodes of care, to avoid high cost outlier status. CMS did not publish data to support this concern but informally referred Kindred to a prior rulemaking record. Kindred believes it is inappropriate and contrary to the Administrative Procedure Act for CMS to rely on this justification or data without including it in the rulemaking record for the specific proposal to extend the 25% rule to freestanding LTACHs. In any event, the data CMS relies on does not support its stated concern.

Specifically, CMS points to the following discussion to support its belief that LTACH utilization results in a decrease in high cost outliers which apparently is the primary justification for the proposed rule to extend the 25% rule to freestanding LTACHs:

> "In analyzing the discharge data, we have looked at data from 1996 through 2003 from our MedPAR files, focusing our data analyses on changes in lengths of stay that exceed the geometric mean cases at host hospitals that are co-located with LTCH HwHs or LTCH satellites as opposed to those without LTCH HwHs or LTCH satellites. Our concern is that, in general, a significant volume of these cases are being discharged to the onsite LTCH prior to reaching outlier status. We compared the number of Medicare covered days for specific DRGs with data from hospitals before and after they became a host hospital. We selected DRGs that MedPAC had identified as being more likely to lead to cases in which a host hospital would transfer the patient from the acute care hospital to their co-located long-term acute care facility.
>
> Acute hospitals were grouped into cohorts for each year from 1996 through 2003: those that were freestanding as distinct from those that currently were hosting a long-term care hospital. For all but one DRG (482), the mean amount of covered days across all years for hospitals that were currently hosting a LTCH was lower in comparison to when they were not hosting a LTCH. Four DRGs (263, 265, 266 and 483) experienced decreases over ten percent. We also looked at covered days for DRGs 483, 126, 264, and 475 for the year 1999 (since all the acute care hospitals in the analysis were not hosting LTCH HwHs or LTCH satellites that year) in comparison to 2002 and 2003 (because all the acute care hospitals in the analysis were hosting LTCH HwHs or LTCH satellites in those years). For most of these DRGs (particularly DRG 483), the number of discharges with a very high number of Medicare days decreases quite significantly at the acute care hospital after it became a host. We believe that this data indicates a correlation between

the presence of a LTCH as a LTCH HwH or a LTCH satellite within an acute care hospital and a shorter length of stay for Medicare beneficiaries at the acute care hospital." (69 FR 49201).

These data do not support CMS's contention that freestanding LTACHs are acting as units of acute care hospitals so as to reduce the number of high cost outlier cases experienced by STACHs:

- The CMS data refers to analysis conducted on Hospital within Hospital LTACHs, not freestanding LTACHs. It would be arbitrary and capricious for CMS to use data wholly inapplicable to freestanding LTACHs to justify a dramatic change in policy;

- CMS relies on old data, from 1996-2003, which is not relevant to current referral patterns, lengths of stay, or the relationship between STACH and LTACH hospitals. First, using old data ignores the numerous policy changes, including the phased-in implementation of the HIH 25% rule, that have intervened since the analysis was done. CMS cannot make any assumptions about the applicability of this old data to current referral patterns without accounting for these changes in policy. As noted above, the 25% HIH rule has not even been fully implemented. Second, as CMS well knows, the geometric means upon which the old data relies change every year as part of the DRG re-weighting process and recalibrating the high cost outlier thresholds. Accordingly, lengths of stay and referral patterns as it relates to the frequency or decline in high cost outlier cases changes from year to year and it is statistically invalid to draw conclusions about changes in lengths of stay relative to DRG thresholds from one year to the next;

- Most important, the analysis relied upon by CMS does not even prove the point they are trying to make, namely, that there is a relationship between LTACH utilization and the percentage of cases that become high cost outliers. Instead, the analysis picks a limited number of DRGs and purports to show a decrease in the number of covered Medicare days spent in an acute care hospital past the geometric mean when HIH LTACHs are present. As shown below, an analysis of all DRGs shows that LTACH utilization is actually associated with an increase—not a decrease—in the percentage of high cost outlier cases experienced by acute care hospitals. Moreover, the CMS analysis is flawed by measuring a change in the number of Medicare covered days rather than the actual percentage of cases receiving high cost outlier payments. As noted below, for one primary DRG relied upon by CMS (DRG 483, Ventilator-Trach patients), the decrease in the number of Medicare days observed by CMS is due to the fact that the majority of these patients are discharged "early," well before the DRG threshold. This "early" discharge results in a reduced Medicare payment below the full DRG amount because this DRG is subject to Medicare's post acute transfer policy payment reduction. Accordingly, the decrease in Medicare days observed by CMS can actually result in lower, not higher, Medicare costs.

An objective analysis of CMS's own data from MedPAR 2005 flatly contradicts CMS's assumption: there is no relationship between the percent of high cost outlier cases in acute care hospitals and the percent of discharges to LTACs. If anything, the data show the opposite, i.e., as the percentage of acute hospital discharges to LTACs increases, the percentage of high cost outliers in acute hospitals also increases, albeit only slightly. The same pattern holds if the percentage of Medicare reimbursement spent on high cost outliers is used rather than the percentage of high cost outliers.

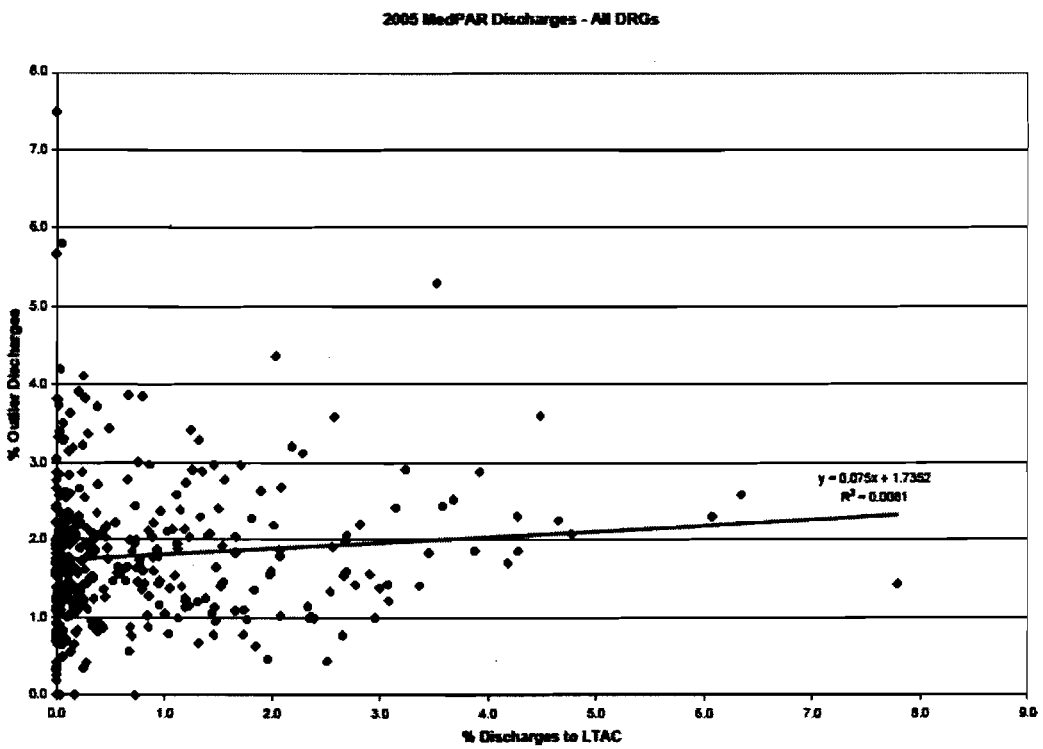
The following charts show the relationship between the percentage of high cost outliers in acute care hospitals and the percentage of total discharges to LTACHs in each of 385 metropolitan areas and metropolitan divisions. Using the appropriate field in MedPAR, the y-axis identifies acute hospital high cost outliers. The x-axis identifies for each acute care hospital the percentage of discharges to LTACHs.

The individual data points on the graph indicate metropolitan areas with varying degrees of discharges to LTACHs. Data points further out on the x-axis indicate markets having a higher percentage of cases being discharged to LTACHs. If it were true that utilization of LTACHs is related to a decline in STACH high cost outlier cases, the chart would show a downward sloping curve. With one exception, the chart shows an upward sloping curve that disproves any notion that STACHs are discharging patients early to LTACHs.

We conducted the analysis for all DRGs, the top 10, 20, 30 and 50 DRGs with the most frequent acute hospital discharges to LTACHs, and for the highest frequency discharge to LTC-DRGs (541 and 542, ventilator-trach patients). The charts show the following:

All DRGs (Figure 1): For all DRGs, the percentage of high cost outliers in acute care hospitals actually increases slightly as the percentage of discharges to LTACHs increases. Specifically, for every 1% increase in the percentage of acute hospital discharges to LTACHs, there is a corresponding .075% increase in the percent of acute hospital high cost outlier cases. This is directly contrary to any concern that use of LTACHs lowers the percentage of high cost outliers.

Figure 1



Top 10, 20, 30 and 50 Frequency DRGs (Figures 2-5): This same pattern holds for the highest frequency DRGs among patients discharged from acute care hospitals to LTACHs. Specifically, the data show that as the percentage of discharges to LTACHs increases, there is essentially no change in the percentage of acute care cases that become high cost outliers--the graph line is flat. Again, this is directly contrary to CMS's stated concern.

Figure 2

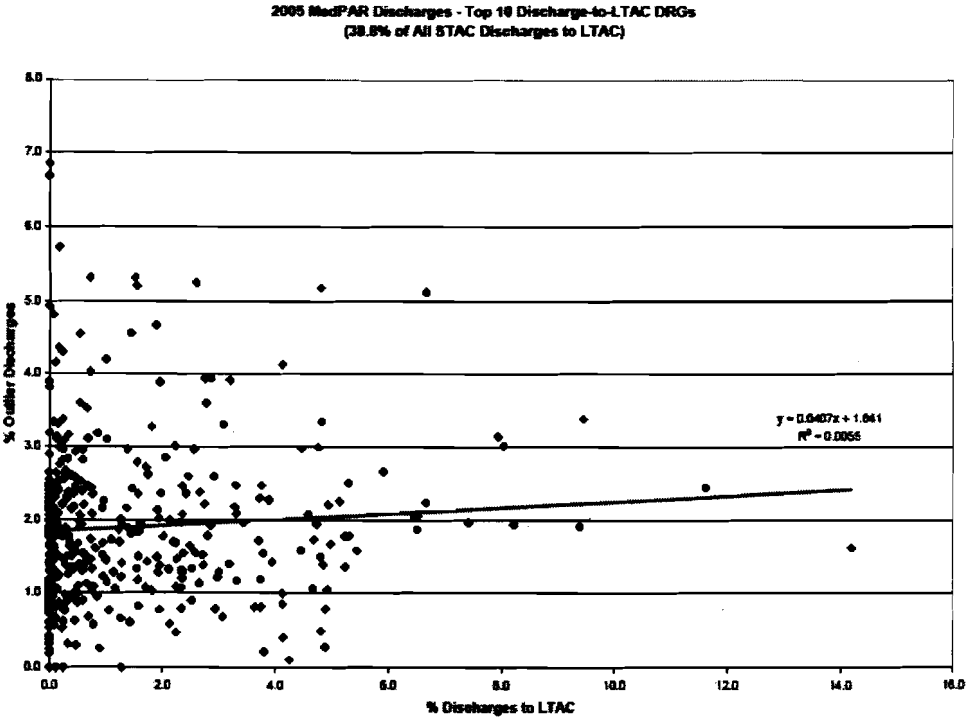


Figure 3

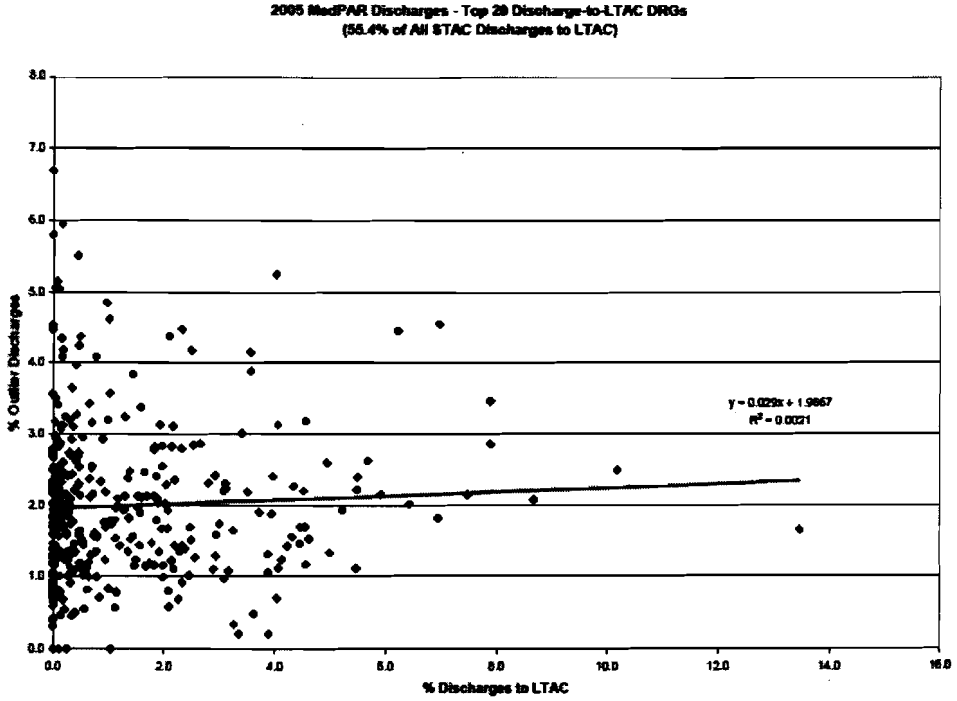


Figure 4

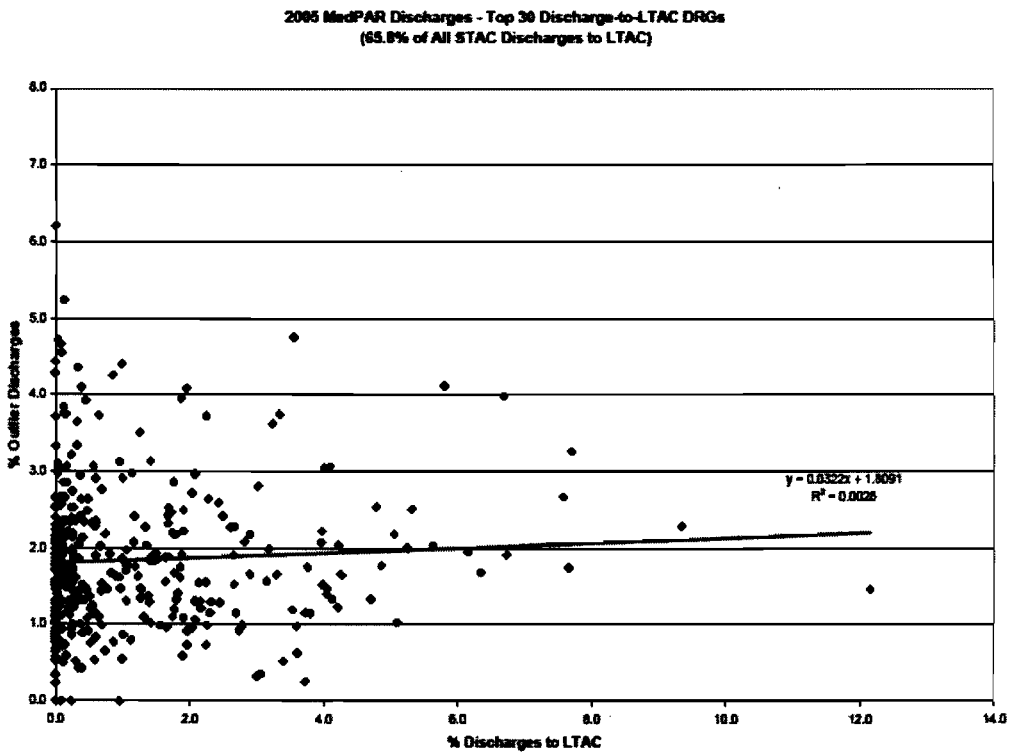
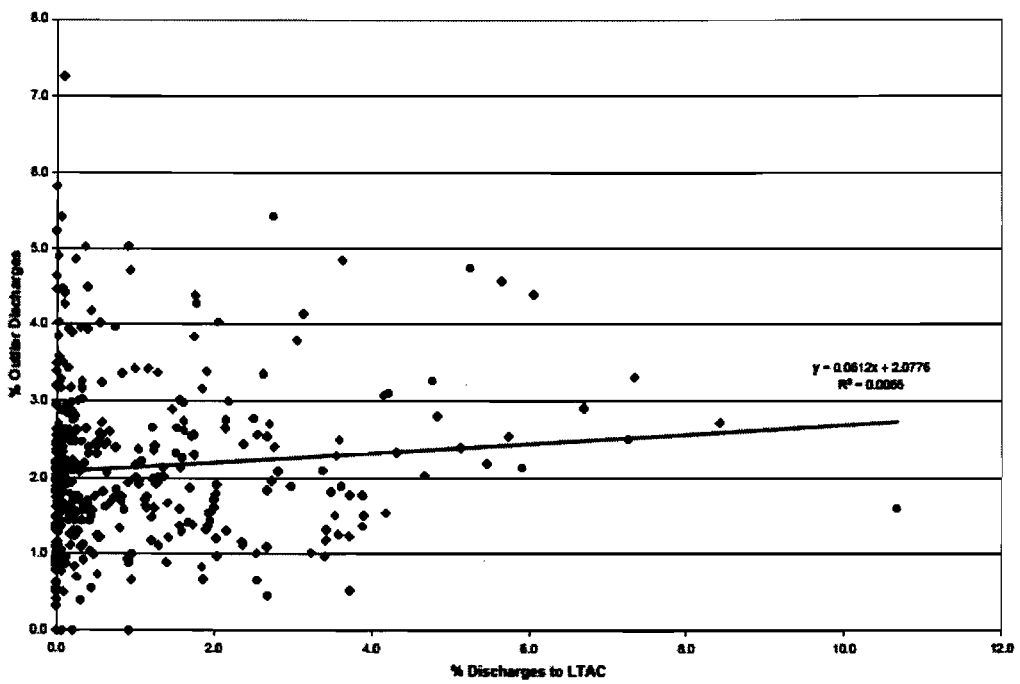
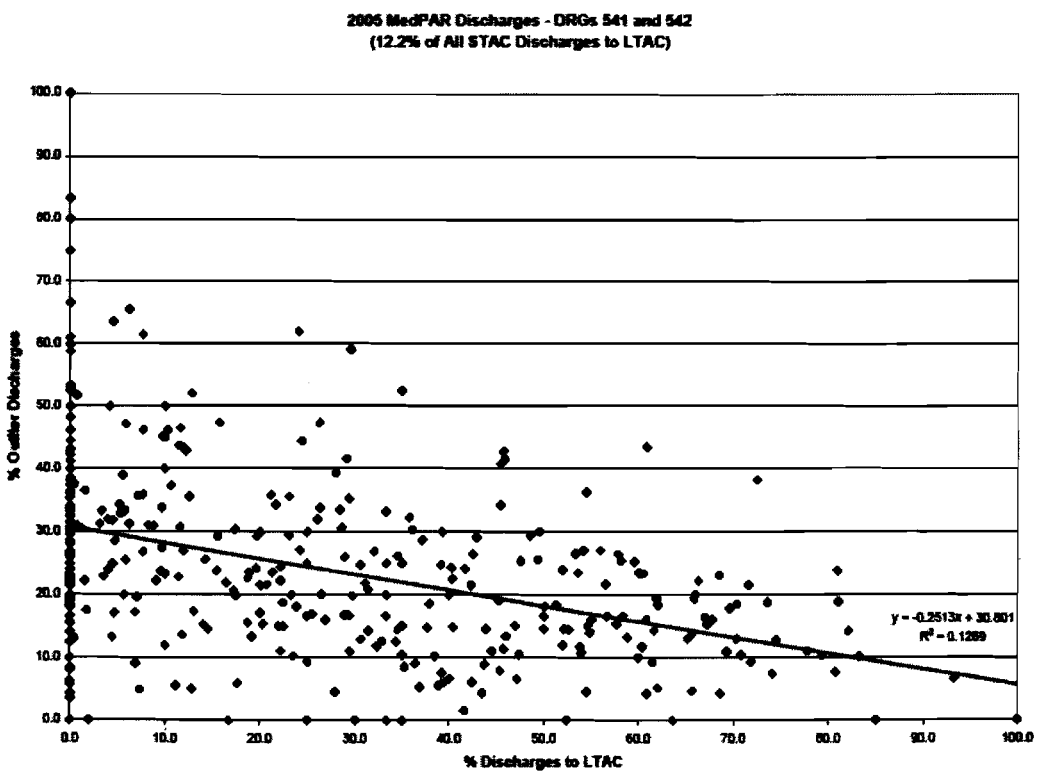


Figure 5



DRGs 541 and 542 (Figure 6): The one exception to these findings is for the most common type of patients discharged from acute hospitals to LTACHs, ventilator-dependent patients who also received a tracheotomy in the acute care hospital. For these patients the data show that the percentage of high cost outlier cases in acute care hospitals declines by less than 1% (0.25%) for every one percent increase in the percentage of cases discharged to LTACHs. In other words, the graph in Figure 6 does show a slight downward slope indicating that use of LTACHs affects somewhat the percentage of high cost outlier cases in acute care hospitals for these patients.

Figure 6



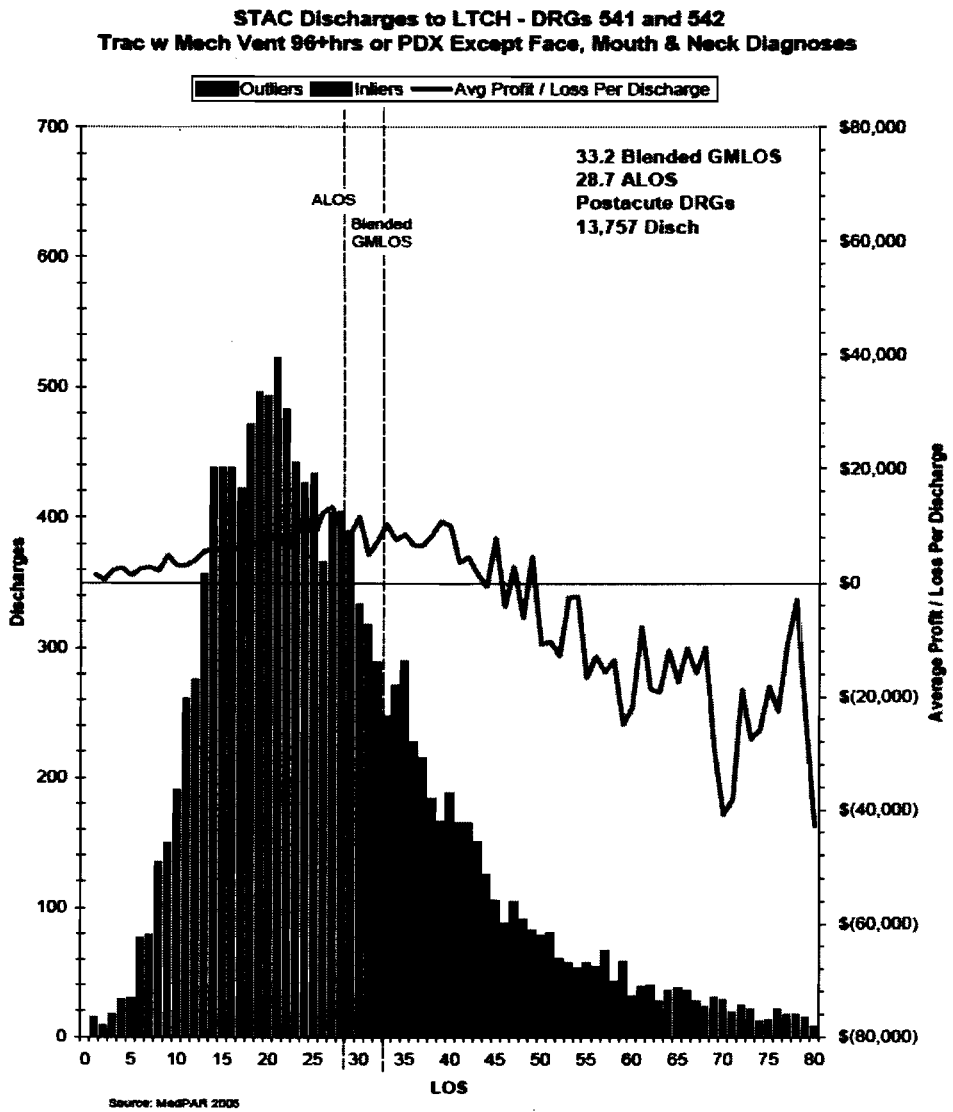
Despite the correlation indicated by the chart, this pattern does not support CMS's concern that LTACH utilization unduly increases costs to the Medicare program, for three reasons:

- First, overall, the percentage of acute hospital high cost outliers for DRG 541/542 patients discharged to LTACHs (17.2%) and comparable patients not discharged to LTACHs (20.0%) is not significantly different;

- Second, although it is obvious that trach/vent patients are discharged "earlier" when LTACHs are available (as indicated by a decline in high cost outlier percentage), the majority of these patients (68.7%) have a length of stay that is more than a day less than the geometric mean for these DRGs and therefore receive a Medicare payment reduction pursuant to the post-acute transfer policy (see Figure 7 below). In other words, the majority of trach/vent patients discharged to LTACHs are paid less than the full DRG amount because they are discharged early, so CMS actually saves some money on these patients. In addition, for trach/vent patients not discharged to LTACHs, the percentage of cases subject to the post-

acute transfer policy is significantly less (49.2%), indicating that Medicare more often pays the full DRG amount for patients not sent to LTACHs.

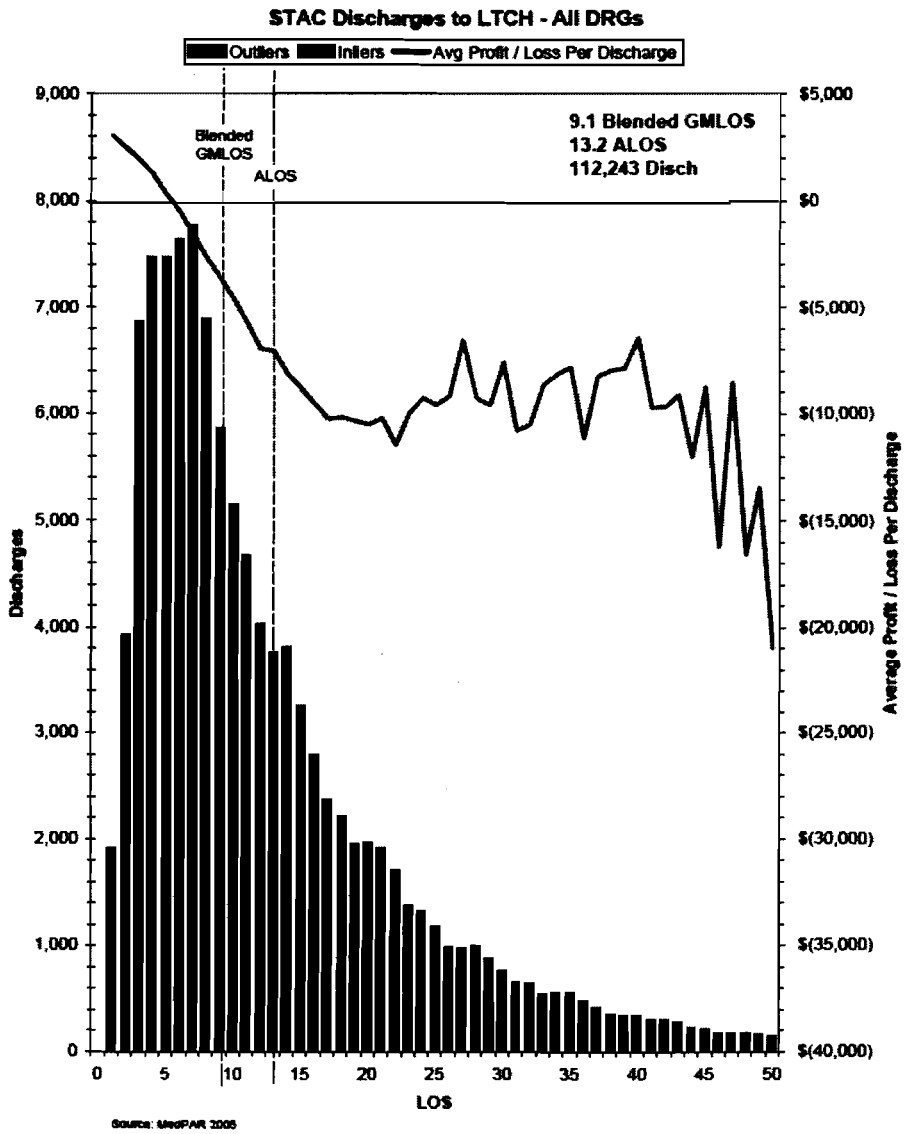
Figure 7



- Third, and equally important, both MedPAC and RTI found that Medicare's total cost for the entire episode of care (including admission to other post-acute venues and readmission to acute hospitals) for this subset of trach/vent patients is no more expensive--and in some cases can be less expensive--than comparable patients not sent to LTACHs. Accordingly, CMS should not be concerned that for this subset of patients there is a somewhat lower percentage of high cost outliers when LTACHs are used.

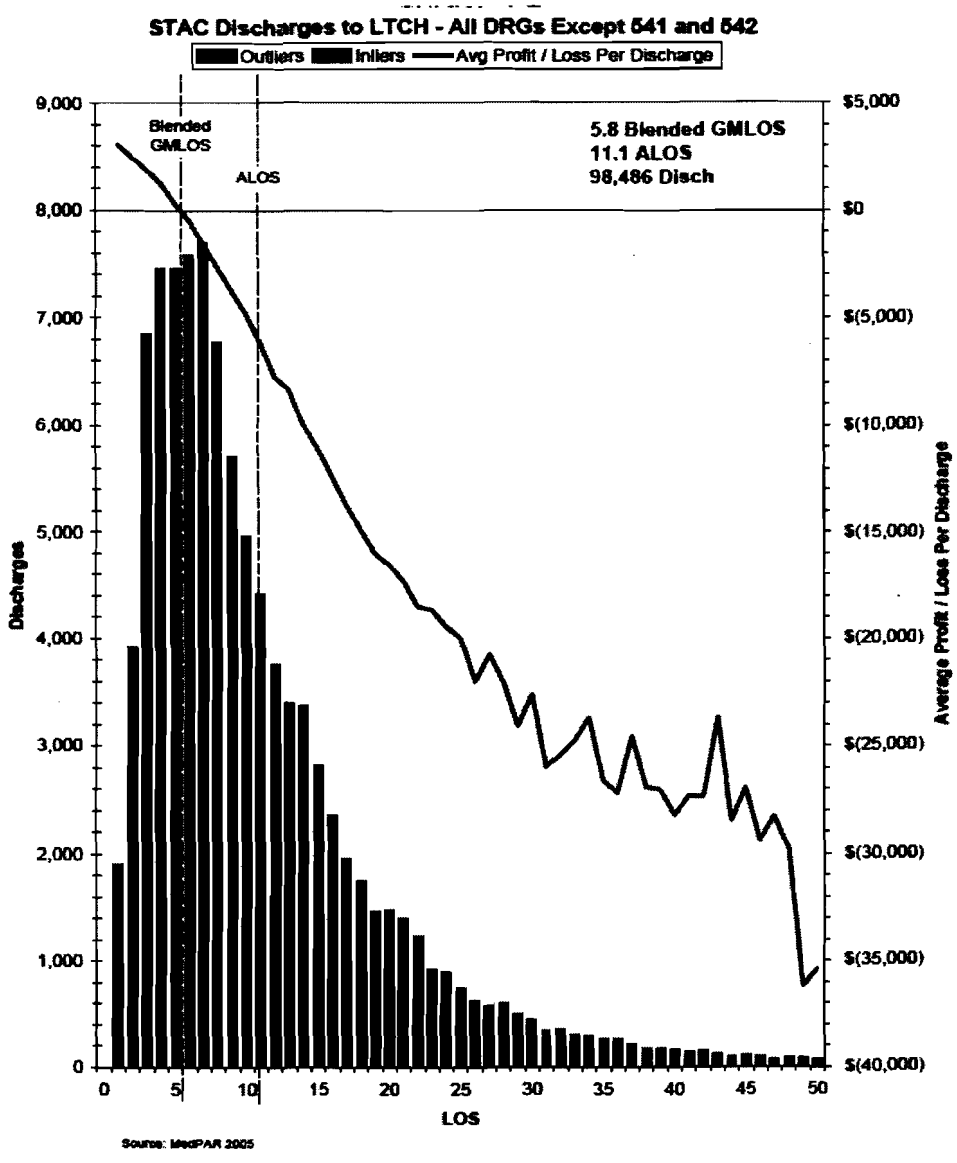
The graph in Figure 8 shows that the ALOS for acute hospital patients eventually sent to LTACHs is more than 4 days longer than the geometric mean length of stay for patients in the same DRGs.

Figure 8



The graph in Figure 9 shows that among non-trach patients, the ALOS for patients eventually sent to LTACHs is nearly twice the geometric mean length of stay for all patients in the same DRGs. This indicates that the more medically complex patients typically sent to LTACHs are staying in the acute hospital longer than the average patient and that acute hospitals are not systematically discharging patients to LTACHs early in order to maximize profits. As we discussed, the one exception to this is DRGs 541/542 where patients are generally discharged earlier than the acute care hospital geometric mean length of stay and payment is adjusted by the post acute transfer policy for nearly 70% of these patients. It is very important to note that 83% of the DRGs applicable to acute hospital discharges to LTACHs are subject to the post acute payment policy.

Figure 9



(4) Publicly Available Data Show that Medicare Is Not Paying Twice for a Single Episode of Care since there is limited overlap between DRGs in STACHs and LTACHs.

For Medicare payment purposes, the "episode of care" for STACHs is defined by the DRG assigned to patients upon discharge. [2] Thus, the only way Medicare could possibly be paying for a

[2] We understand that the term "episode of care" for Medicare patients typically refers to patients' "entire episode" throughout the acute and post-acute system. In contrast, CMS's purported concern here is that Medicare not pay "twice" for the episode of care for the patient *within the short-term acute care hospital*. For this specific question, the episode must be defined for payment purposes by the DRG assigned to the patient for the episode experienced *in the acute care hospital*.

single episode of care is if a patient discharged from a short-term hospital with a specific DRG is assigned the same DRG when discharged from an LTACH.[3] But MedPAR data shows there is very little overlap between the most common DRGs assigned to patients when discharged from STACHs to LTACHs and the DRGs assigned to the same patients when discharged from LTACHs. These data rebut CMS's assumption that Medicare is paying twice for a single episode of care.

If CMS is correct in assuming that patients in STACHs discharged to LTACHs are effectively continuing the same episode of care, then the case counts for common DRGs for patients in STACHs who are sent to LTACHs would match the case counts in those DRGs for patients discharged from LTACHs. But that is not what the data shows. There is no one-to-one ratio of cases for STACH patients and LTACH patients in any of the most frequent DRGs assigned to patients in STACHs who are ultimately sent to LTACHs. There are only 6 DRGs in the top 100 most frequent LTACH DRGs where the count of cases in both settings comes close to a one-to-one ratio (defined as less than a 25 case disparity). The average disparity in case counts across the two settings is 952 cases. The reason for the disparity in case counts is clear: patients treated in the STACH were assigned a different DRG reflecting a different episode of care than what they received when they were discharged from the LTACH.

Table 2

1	475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	16,102	4,277	4
2	271	SKIN ULCERS	6,601	1,047	27
3	87	PULMONARY EDEMA & RESPIRATORY FAILURE	6,108	1,596	16
4	79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	5,894	2,824	9
5	88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	5,414	2,630	11
6	249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	5,357	140	117
7	89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	5,263	3,766	6
8	12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	5,175	660	38
9	466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	5,034	7	334

Source: MedPAR 2005

[3] Even if the patient is assigned the same DRG it is not true, per se, they have the same episode of care because patient's characteristics and needs – and therefore the specific course of treatment – could differ significantly even within the same DRG. Specifically, Congress has authorized payments to LTACs for patients with lengths of stay, on average, greater than 25 days regardless of the DRG assigned. See 42 U.S.C. § 1395ww(d)(1)(B)(iv)(I).

(5) Ventilator Patient Data Show Separate Episodes of Care in the STACH and the LTACH by DRGs, and Different Patient Characteristics and Course of Treatments.

Further evidence that Medicare is not paying twice for a single episode of care is available by examining DRG codes for ventilator patients, the most common LTACH patient. There are different DRGs for patients on ventilators reflecting fundamentally different patient conditions, care protocols, lengths of stay and ultimately episodes of care. Examination of data for these DRGs conclusively rebuts CMS's presumption that Medicare is paying twice for a single "episode of care" for these patients.

The most common discharge DRGs for patients discharged from STACHs to LTACs is DRGs 541 and 542 (for patients who have had the surgical procedure for a tracheotomy in addition to being ventilator dependent). These are the most medically complex ventilator patients with an average length of stay in the acute hospital of over 35 days. These patients required a tracheotomy because it is anticipated they will be dependent upon a ventilator for prolonged periods of time. In 2005, there were 13,753 discharges from STACHs to LTACHs in DRGs 541 and 542, or 12.26% of all discharges from STACHs to LTACHs. At the same time, there were only 1,212 patients (0.89%) with DRGs 541 and 542 discharged from LTACHs.

Another DRG related to ventilators is DRG 475, assigned to patients who were dependent on a ventilator but did not receive a tracheotomy. These patients are less medically complex, have shorter lengths of stay, and most are not even dependent on a ventilator when they are discharged from the acute care hospital. It is less common for DRG 475 patients to be discharged from acute hospitals to LTACHs. In 2005 there were only 4,277 STACH patients classified into DRG 475 who were subsequently discharged to LTACHs. Yet, there were 16,102 patients discharged from LTACHs classified into DRG 475.

Differences in patient characteristics and the course of care explain the disparity in DRG frequencies across these two settings. Most of the 16,102 LTACH patients receiving ventilator support services under DRG 475 in the LTACH were placed on a ventilator along with receiving a tracheotomy in the STACH prior to being admitted to an LTACH. As a result, these patients were generally classified into DRGs 541 or 542 upon discharge from the STACH. The 16,102 patients discharged from LTACHs with vents were not classified into DRG 541 or 542 because they were already had a tracheotomy and were on both a ventilator and trach when they arrived at the LTACH. Instead, these LTACH patients are classified into DRG 475. The different course of treatments explains why the data show 13,753 STACH patients discharged to LTACHs were classified into DRG 541 or 542. Simply stated, this important subset of patients experience different episodes of care in the STACH and the LTACH, based upon different patient characteristics and different courses of treatment, as reflected in the assignment of different DRGs.

If CMS decides to finalize this policy, which we firmly object to based upon the data discussed herein, under its own rationale CMS must limit the 25% rule extension to LTACH discharges who had the same DRG upon discharge from the STACH. Likewise, the "IPPS equivalent" payment adjustment should be based on the DRG that the same patient had the supposedly same episode of care in the STACH.

(6) Because There Are No Data to Support CMS's Assumptions, It Is Inappropriate for CMS to Extend the 25% Rule to Freestanding LTACHs.

For all the above reasons, the assumptions supporting this proposal are not based on the data and in fact are refuted by available data. Accordingly, it is inappropriate for CMS to extend the 25% rule to

freestanding LTACHs because it would not pass the "rational basis" test under the courts' interpretation of the Administrative Procedure Act ("APA").

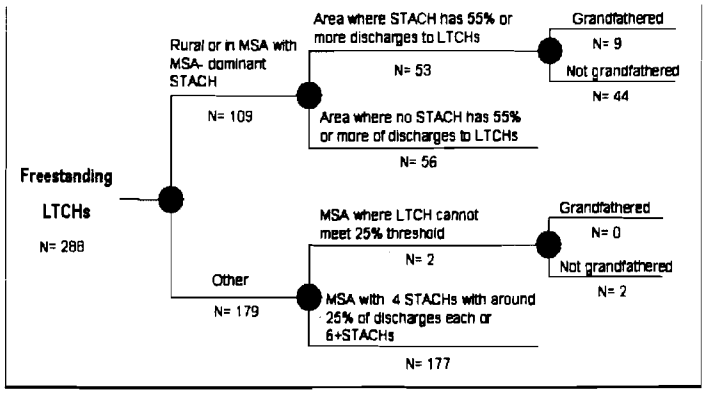
c. The Proposed Rule Will Result in a Number of Unintended Consequences that Weigh Against Its Implementation.

(1) The Proposed Rule Will Have a Disparate Impact on LTACHs in Rural and Quasi-Rural Areas With Fewer Referral Sources.

An immediate impact of the proposed rule, if finalized, will be experienced in markets with less than four STACHs or in markets where a single STACH specializing in treating medically complex patients accounts for a large percentage of Medicare LTACH discharges. In these markets, it is likely that medically complex patients will not be evenly distributed and the LTACH's patient census will be affected by this proposed policy. The usual dynamic is for patients who later require LTACH care to cluster at a tertiary care center. A patient quota system, like the one proposed, applied evenly to all STACHs in the market will prevent the LTACHs in that market from operating as effectively as MedPAC and RTI envision since *referrals will be most restricted from the STACH whose caseload is most in need of LTACH services*. Rather than reward the referral and discharge relationships between STACHs and LTACHs for improving the patient continuum of care, CMS would penalize these relationships based upon false assumptions.

The effect of this penalty will be felt the most in underserved areas. A safety net of 50% for LTACHs in underserved areas is wholly inadequate. Some of these LTACHs only have one STACH referral source. In these areas, it is *irrefutable* that a 50% rule will limit access to patient care, restrict patient choice, and trump medical decision-making. Figure 10 shows that there are 84 free-standing LTACHs in rural or MSA-dominant geographic areas. Well over half of these LTACHs (60%) operate in markets where one STACH discharges more than 55% of all Medicare LTACH discharges. This means that it is impossible for these LTACHs to comply with CMS's proposal to extend the patient quota rule to freestanding LTACHs. It will be difficult even for the remaining 40% of quasi-rural LTACHs to comply since a small number of hospitals account for a large portion of discharges to LTACHs. In short, CMS's proposal imposes a penalty on rural and quasi-rural LTACHs and STACHs with their proposed rule.

Figure 10



Source: MedPAR

(2) The Proposal Will Result in Patients being Referred to LTACHs Based Exclusively on the 25% Rule Rather Than Quality, Physician Direction, Consumer Choice, or Efficiency.

CMS should be aware that most of Kindred's freestanding LTACHs have been certified Medicare providers for long periods of time, are deeply rooted in their healthcare markets, and typically have operating models that do not rely on single acute care hospitals as primary referral sources. Instead, Kindred's freestanding LTACHs tend to have a broad base of referral sources based on longstanding relationships built over the years because of a reputation for providing quality of care. As such, based on current referral patterns, Kindred's freestanding LTACHs would not be affected by the 25% rule extended to freestanding LTACHs to the same degree as other LTACHs or to the degree that CMS projects.

Nevertheless, Kindred adamantly opposes the proposal because of a concern about the dislocating effect a 25% rule would have on all LTACHS, including Kindred. Simply put, CMS's proposal may force STACHs to adjust their patient referral patterns such that patients will be sent to LTACHs exclusively on the basis of compliance with the 25% rule, ignoring all clinical and other market factors that should be the primary determinants of patient placement. LTACHs will not be able to admit patients over the 25% threshold at the rates proposed by CMS because the rates fall so far below cost that care cannot be provided to these medically complex patients. In order to comply with the 25% rule, patient referrals from STACHs to LTACHs will not be made on the basis of quality, consumer preference, physicians' determinations about a match between LTACH specialties/competencies and patient needs, or any other market-based factor. Instead, referrals will be made exclusively on the basis of compliance with the 25% rule and this will potentially alter existing patient referral patterns. As a result, there may not be a reduction of patients sent to LTACHs, but simply a redistribution of where patients are sent.

Given the current geographic distribution of freestanding LTACHs and the percentage of Medicare discharges by STACHs in these same geographic areas, "compliance" with a 25% rule is practically feasible-- but only if the current patient referral patterns change dramatically in order to adjust to the new rule. Figure 10 shows markets in which there are four or more STACHs with roughly 25% of LTACH Medicare discharges. The Figure shows that in certain rural and quasi-rural areas compliance with a 25% rule is unfeasible. It also shows that in most other markets compliance would be technically feasible if referral patterns changed. These data point to three distorting effects of CMS's proposed policy. First, as noted above, patient referral decisions would be based primarily on compliance with the 25% rule, not clinical, quality or other market-based factors that should drive patient placement. Second, since compliance is technically feasible, it will not result in the budget savings CMS projects except to a more limited degree in rural and quasi-rural markets. Third, the policy will arguably perpetuate the geographic maldistribution of LTACHs that policymakers have noted.[4] This is true because the change in patient referral patterns described above can only occur in markets where there is already a concentration of LTACHs, so the perverse effect of CMS's proposed policy is to make compliance with a 25% rule possible only where there is already a concentration of LTACHs.

Kindred opposes extending the 25% rule to freestanding LTACHs not because of the effect that it can have on our patients today, but because of the dislocating effect it could have in the future. We

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[4] Kindred agrees that there are some geographic markets where the number of LTACHs appear disproportionate to the population served. Kindred also notes that the geographic dispersion of LTACHs is evening out and there is a growing correlation between the presence of LTACHs, the percentage of "LTACH-appropriate" patients as reflected in medically complex diagnoses, and the concentration of Medicare populations. Nevertheless, there continues to be some geographic maldistribution of LTACHs that, in our view, can be effectively addressed through certification criteria.

also emphasize that we are not suggesting that changes in referral patterns as described above would be untoward or as a result of collusive patient shifting. On the contrary, the changes would occur because both STACHs and LTACHs are attempting in good faith to comply with CMS's policy that no more than 25% of patients should be admitted to an LTACH from a primary referral source. This policy cannot be justified on the basis of data or policy goals. The primary impact of the rule would be to force a change in patient referral patterns in an irrational way inconsistent with the best interests of patients or the Medicare program.

d. If CMS Chooses to Adopt the Proposed Rule, Existing Freestanding LTACHs and Freestanding LTACHs Under Development Should Be Afforded Grandfathered Status and Exempt from the 25% Rule; Alternatively, Current Freestanding LTACHs should be Afforded the Same Grandfather Status as HIH LTACHs on the Basis of Certification Date.

Application of the payment limitation threshold to existing and under-development LTACHs will have a substantial negative impact on the ability of existing LTACHs to continue to provide care to Medicare beneficiaries requiring LTACH-level services. Existing LTACHs were developed to comply with the rules governing LTACH PPS at the time they were certified and could not have predicted that CMS would so dramatically alter the payment system as to limit payment under LTACH PPS to no more than 25% of the facility's patients who are admitted from one STACH. By continuing to alter the rules governing LTACH PPS, CMS creates an immeasurable degree of uncertainty among providers that ultimately results in increased costs and inefficiency in providing Medicare services.

Some existing LTACHs were developed in communities where a large STACH system necessarily refers to the LTACH more than 25% of admissions. As described above, it can be anticipated that the 25% rule applied to freestanding LTACHs will have serious market dislocating effects by altering relationships between STACHs and LTACHs and dramatically changing patient referral patterns. In some cases the 25% rule will result in LTACHs voluntarily decertifying from the Medicare program, which will only further increase the impact of the 25% rule on LTACHs remaining in the same service area. The same reasons that lead CMS to initially establish a grandfathering provision at 43 C.F.R. 412.22(f) are relevant to the application of the proposed rule to freestanding and under-development LTACHs. As observed in the August 1, 2003 IPPS update final rule for FY 2003, "in establishing grandfathering provisions, [CMS's] general intent has been to protect existing hospitals from the potentially adverse impact of recent, more specific regulations that we now believe to be essential to the goals of the Medicare program." 68 Fed. Reg. at 45,463. If CMS insists on implementing the payment limitation threshold on all admissions from non-co-located hospitals, CMS should afford existing freestanding and under-development LTACHs with the same protection it granted to certain HIHs.

Likewise, in the preamble to the proposed rule, CMS suggests that LTACHs may be evading the existing 25% rule by establishing non-co-located freestanding LTACHs in close proximity to a referring hospital. To date, CMS has provided no evidence that LTACHs are relocating for the sole purpose of avoiding the existing 25% rule. Nevertheless, if this is CMS's primary concern, then CMS should exercise its regulatory authority to address what it believes are abusive practices rather than adopting a wholesale rule that harms freestanding LTACHs that have operated according to CMS rules for a long period of time. If CMS's concern is related to "new" freestanding LTACHs believed to be evading the regulations by establishing operations in proximity to STACHs, then the proposed extension of the 25% rule should be applied only to new freestanding LTACHs. Existing freestanding LTACHs should be afforded grandfather status since they are complying with CMS regulations.

Alternatively, if CMS chooses not to afford grandfather status to all existing and under development freestanding LTACHs, CMS should at least afford grandfather status to freestanding

LTACHs on the same terms and conditions that currently apply to certain HIH LTACHs pursuant to 42 C.F.R. 412.22(f). In other words, freestanding LTACHs certified before September 30, 1995 should be afforded grandfather status.[5]

e. If Finalized, CMS Should Apply the Proposed 25% Rule on a Facility Specific, not Provider Number, Basis.

We understand from correspondence with CMS that the proposed rule would apply to each individual hospital referral source to the LTACH and affect Medicare discharges from all LTACHs or LTACH satellites, regardless of whether the patient was admitted from a hospital located in the same building or on the same campus of the LTACH or satellite. It is also our understanding that, if a referring hospital has a remote campus and both the main hospital campus and the remote campus refer patients to an LTACH, the percentage of the LTACH's discharges admitted from the remote campus that exceed 25% (or the applicable percentage) will be separately subject to the payment adjustment from the percentage of the LTACH's discharges admitted from the hospital's main campus. We strongly believe that if CMS adopts the 25% rule as final that this interpretation of its application apply. As a reading of the proposed rule and the accompanying preamble may lead to several interpretations of how the 25% rule would be applied in this scenario, we ask that CMS confirm or clarify this in the final rule.

3. Kindred Position and Alternatives

For the reasons discussed above, and based on the data presented, CMS should not finalize the proposed, or any similar, policy that extends the current 25% rule to freestanding LTACHs or grandfathered LTACHs. However, if CMS finalizes this policy in spite of industry opposition, it should modify that policy in the following ways:

- Grandfather all existing and under-development freestanding LTACHs from the rule altogether. Alternatively, CMS could afford Grandfather status to freestanding LTACHs on the same basis that the current HIH grandfather rules apply, based on certification date.
- Not revoke grandfather status for HIHs currently afforded grandfather status.
- Provide for a longer phase-in period – at least as long as the phase-in period for HIHs and satellites (4 years).
- Under its own rationale CMS must limit the 25% rule extension to LTACH discharges who had the same DRG upon discharge from the STACH. In addition, the "IPPS equivalent" payment amount should be based on the DRG assigned to the patient in the STACH.

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[5] Use of the existing 412.22(f) provision to grandfather existing LTACHs is problematic, however, because it measures certain changes in an LTACH's condition of participation over a period of time (e.g., bed capacity, square footage, etc.). These hospitals may have changed those conditions unaware that it would be affecting their status under this provision, if adopted in this manner. Accordingly, Kindred recommends that freestanding LTACHs certified before September 30, 1995 be afforded grandfather status even if these hospitals subsequently changed the terms of their Medicare participation. Of course, changes that occur after the rule takes effect would compromise grandfather status.

B. Short Stay Outlier ("SSO") Policy Proposal

1. Summary of Proposal

The proposed rule would revise the payment adjustment formula for short stay outlier ("SSO") patients. SSO cases are defined as LTACH 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) 100% of estimated patient costs; (2) 120% of the per diem of the LTC-DRG multiplied by the length of stay of that discharge; (3) the full LTC-DRG payment; or (4) a blend of 120% of the LTC-DRG specific per diem amount and an amount comparable to the IPPS per diem amount. CMS now indicates that it is considering lowering LTACH payment to the IPPS rate for cases with a length of stay that is less than the average length of stay plus one standard deviation for the same DRG under IPPS (the so-called "IPPS comparable threshold").

In the preamble to the proposed rule, CMS repeatedly raises the concern that under the existing SSO policy "these cases most likely did not receive a full course of a LTCH-level treatment in such a short period of time and the full LTC-DRG payment would generally not be appropriate." 72 Fed. Reg. at 4,804. CMS remains convinced that "many SSO patients could otherwise have continued to receive appropriate care in the STACH from which they were admitted." 72 Fed. Reg. at 4,805. In other words, CMS offers the same rationale offered for proposing to extend the 25% rule to free-standing LTACHs, namely, that Medicare should not be paying twice for a single episode of care. For these reasons, CMS announced in the proposed rule that it is considering lowering LTACH payment to the IPPS rate for SSO cases with a length of stay of the IPPS comparable threshold.

CMS estimates the impact of this proposal as a 0.9% decrease in aggregate LTACH payments.

2. Kindred Response

a. CMS Must Propose Regulatory Language Before It Can Finalize This Proposal.

In the preamble to the proposed rule, CMS stated that it is considering a change to its SSO policy, and requested comments on the proposed policy. However, in violation of section 533(b) of the Administrative Procedure Act ("APA"), CMS provided no specific regulatory language to implement this proposed policy. See 5 U.S.C. § 533(b)(requiring a notice of proposed rulemaking to include "the terms or substance of the proposed rule"). Without adequate notice of the regulatory language that CMS intends to use, interested parties are improperly limited in the degree to which they are able participate in the rulemaking process. See United Church Board for World Ministries v. SEC, 617 F. Supp. 837, 840 (D. D.C. 1985).

b. Expanding the SSO Policy Is Premature When CMS Has Failed to Evaluate the Effect of Changes to the Policy Implemented Less Than One Year Ago.

The existing SSO policy became effective as recently as October 1, 2006. Consequently, the most recent changes to the SSO policy will have been in effect for less than one year before the proposed change would take effect. CMS is proposing a change to an existing policy whose current impact is undetermined. Before rushing to adopt another change to the SSO policy, CMS should determine if the change implemented in RY 2007 met the intended goal. There has been insufficient time to determine the impact of the last change to the SSO policy.

After the SSO policy changes of last year, LTACHs no longer have an incentive to knowingly admit these kinds of SSO cases. By reducing the option that SSO cases be paid 100% of the estimated cost of the case from 120% of costs, the RY 2007 final rule adequately discouraged the inappropriate admission of patients that do not typically belong in LTACHs, but who would be more appropriately treated in another setting. Reducing the SSO payment further will result in additional cuts in LTACH payment before LTACHs, or CMS, have assessed the impact of the prior year's reduction.

c. CMS Incorrectly Assumes that SSO Cases with a Similar Length of Stay as STACH Cases are Continuing the same Episode of Care.

There is no data to support the conclusion that patients within the IPPS comparable threshold are clinically similar to STACH patients or have continued the same episode of care that began in the STACH. Accordingly, these cases should not be subject to payment comparable to the IPPS per diem amount. As demonstrated above:

1. LTACH Patients Discharged from STACHs are assigned Different DRGs in the Two settings for two separate Episodes of Care.

2. The Most Common LTACH Patient – Those dependent on ventilators with tracheotomies – are assigned different DRGs in the STACH and LTACH reflecting a different Episode of Care.

The flaw in CMS's premise is graphically illustrated with the most common discharge DRG for LTACHs, DRG 475 (Ventilator Dependent Patients). As discussed at length above, the vast majority of LTACH patients assigned an LTC-DRG of 475 were not assigned an acute hospital DRG of 475 upon discharge from the STACH. Instead, most of these patients were assigned a DRG of 561 or 562, reflecting the clinical fact that in addition to a ventilator these patients received surgical implantation of a tracheotomy. This clinical characteristic reflects a profound difference in patients. It also underscores the fallacy of CMS's proposed payment adjustment. STACH patients with a DRG of 475 are fundamentally different in terms of clinical characteristics, costs, severity of illness and length of stay from the LTACH DRG 475 patient. Evidence of these differences appears in the basic fact that the majority of patients discharged from STACHs with a DRG of 475 **are discharged without even being on a ventilator.** These patients were assigned a discharge DRG of 475 because at some point during their acute hospital stay they were placed on a ventilator and the DRG coding software requires that DRG 475 be assigned under these circumstances. To use the acute DRG 475 payment level to pay for LTC-DRG 475 patients ignores fundamental differences in the patient populations.

To examine this issue, the University of Louisville School of Public Health analyzed 285 patient discharges from a large, urban acute care hospital in Louisville, Kentucky. All 285 patients were assigned a DRG code related to ventilators, either DRG 475 (ventilator dependent) or DRGs 541/542 (ventilator dependent with a tracheotomy). Key findings were as follows:

- 81% of live patients discharged with a DRG of 475 were discharged without being on a ventilator. In other words, the vast majority of these patients were placed on a ventilator for some period of time in the STACH, but were taken off the ventilator prior to discharge. Only a small fraction of these patients (8%) were admitted to LTACHs and instead went to other post-acute settings such as SNFs, IRFs or home health. A majority of the DRG 475 patients discharged still on a ventilator were admitted to LTACHs (68%).

- In contrast, 59% of live patients discharged with a DRG of 541/542 (ventilator with tracheotomy) were discharged while still on a ventilator. The overwhelming majority of these patients (97%) were admitted to LTACHs. These patients are assigned LTC-DRG 475

upon discharge from the LTACH. A majority of the DRG 541/542 patients discharged off of ventilators (67%) went to post-acute settings other than LTACs.

The implication of this data on CMS's SSO policy discussion is profound. CMS proposes to pay LTACHs the IPPS rate for DRG 475 patients when the patients are fundamentally different. A large majority of STACH DRG 475 patients leave the STACH without even being on a ventilator, which reflects a fundamentally different clinical profile and cost than the LTACH DRG 475 patient. The LTACH DRG 475 patient typically is not only dependent on a ventilator but also received surgical implantation of a tracheotomy during their previous acute care hospital stay. These patients have a higher severity of illness, consume many more resources and, consequently, Medicare payments are higher to account for these clinical characteristics. The proposed change in the SSO policy ignores this fact.

CMS should not make changes to the SSO policy. If it does, to be logically consistent and if it is assumed that LTACH cases within the IPPS comparable threshold are comparable to IPPS cases, then the LTACH should be paid the IPPS rate based on the DRG that was assigned to the patient upon discharge from the STACH. In the case of the LTACH DRG 475 patient, the LTACH should be paid at a rate comparable to IPPS DRGs 541/542, reflecting the fact that the acute "episode of care" was for a patient on a ventilator as well as receiving a tracheotomy.

d. The Proposed Policy Incorrectly Concludes that LTACH SSO Cases are Clinically Similar to STACH Patients With Similar Lengths of Stay.

In the discussion of SSO cases, CMS repeats its conviction that many SSO patients could have continued their treatment in the STACH, but were instead prematurely transferred. CMS identifies certain SSO cases as having an episode of care in the LTACH that closely resemble the episode of care in the STACH. This premise, on which the proposed change in policy is based, is flawed because CMS is comparing LTACH SSO cases to STACH cases based solely on their length of stay. This rudimentary comparison does not take into consideration patient severity of illness, which clearly shows that LTACH and STACH patients with the same DRG are <u>not</u> the same kinds of patients. An analysis of these "IPPS comparable cases" using MedPAR 2005 data and the APR-DRG Grouper shows that very short-stay outliers ("VSSOs")[6] are more clinically similar to other LTACH cases than STACH cases in terms of their acuity. As Table 3 below indicates, for 5 of the most common LTACH cases, the SSO cases have a similar percentage of cases in severity of illness ("SOI") categories 3 and 4 as all LTACH cases, and a much higher percentage of cases in SOI categories 3 and 4 than STACH patients.

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6 For purposes of this letter, Kindred has adopted CMS's definition of very short-stay outliers as those cases where a LTACH patient's covered LOS at the LTACH is less than or equal to the ALOS plus one standard deviation for the same DRG at a STACH or the "IPPS comparable threshold." Despite Kindred's use of this terminology, we do not agree that these cases actually have short stays. For example, DRG 565 patients with a LOS of 23 days are just below the IPPS comparable threshold, but can not be considered short stay patients as their LOS is so close to the 25-day LTACH threshold.

Table 3

475	8.0	96%	89%	14.7	94%	83%	34.2	94%	82%
87	4.9	72%	57%	13.4	88%	67%	24.8	91%	71%
88	4.0	26%	14%	9.8	53%	32%	19.3	60%	38%
271	4.6	43%	20%	13.2	73%	47%	26.9	74%	45%
89	4.6	44%	19%	10.0	69%	37%	20.6	75%	37%
All DRGs	4.3	25%	14%	12.8	66%	47%	26.6	69%	48%

Table 4 below excludes SSO data and replaces it with VSSO data. As you can see, the SOI scores for the VSSOs are on par with, and actually slightly higher than, the SOI scores for all LTACH cases.

Table 4

475	8.0	96%	89%	10.1	94%	85%	34.2	94%	82%
87	4.9	72%	57%	5.7	87%	71%	24.8	91%	71%
88	4.0	26%	14%	4.7	52%	34%	19.3	60%	38%
271	4.6	43%	20%	6.1	74%	49%	26.9	74%	45%
89	4.6	44%	19%	5.1	70%	43%	20.6	75%	37%
All DRGs	4.3	25%	14%	7.5	71%	55%	26.6	69%	48%

Table 4 illustrates the significant difference in SOI in VSSO cases compared to STACHs. As Kindred has noted in previous comment letters, it is not possible for an LTACH to determine upon admission the patient's length of stay and DRG classification when these patients appear clinically similar to other patients admitted to an LTACH, as Table 4 indicates. Because these cases are clinically similar to other LTACH cases, Kindred believes it is appropriate for CMS to pay for them under the LTACH PPS. The average medical complexity (as measured by SOI and ROM) and length of stay of VSSO cases are far higher than for STACH patients, and thus it is not surprising that the average costs for VSSO patients are above the IPPS DRG payment amounts. Since there is no evidence that VSSOs are in any way similar to STACH patients, there is no basis for paying for such cases using IPPS methodology.

e. It Is Inappropriate to Base LTACH Reimbursement Policy on the Length of Stay Distribution of Short Term Acute Care Hospital Patients.

Superimposing STACH LOS distribution patterns, especially in instances where there are large standard deviations, on LTACH patients as a way of defining LTACH patients is not supported by data or common sense. Using the IPPS ALOS plus one standard deviation methodology to describe very-short-stay LTACH cases results in 8 DRGs in which the IPPS comparable threshold exceeds 25 days, the statutorily-defined ALOS for LTACH patients. For example DRG 504 (Extensive Burns or Full Thickness Burns) has a GMLOS of 37.1 days and the SSO threshold is 30.9 days. According to CMS's methodology for determining LTACH patients that are VSSOs, DRG 504 burn cases staying less than

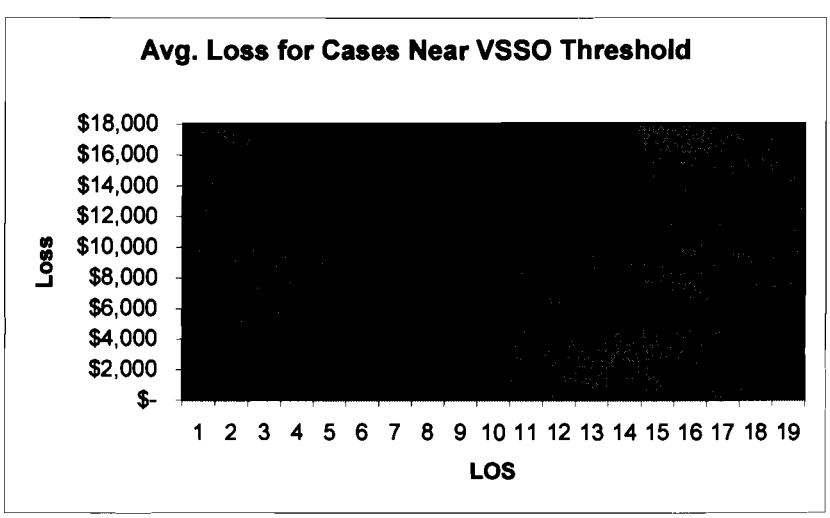
48.4 days in the LTACH would fall into this category. There are 13 DRGs according to CMS's table in the proposed regulation in which the IPPS comparable threshold is longer than the short-stay outlier threshold (5/6th the GMLOS), meaning that patients with LOS longer than the short-stay outlier threshold would fall into this new category of patient. The CMS methodology is inherently flawed in defining VSSO LTACH cases.

f. The Proposed Change Would Create a Significant Payment Cliff and Has a Disproportionate Impact on Longer Stay, Medically Complex Patients.

Analysis of the proposed SSO payment methodology using MedPAR 2005 data indicates that 7,425 cases would have reduced payments under this policy change, and for all of these cases the methodology CMS discusses would pay LTACHs at rates below their costs. According to our analysis, approximately 55% of the cases that would receive a reduced payment are within 2 days of exceeding the IPPS comparable LOS for the DRG. Implementing this policy would create a payment cliff by paying dramatically different amounts for cases with similar lengths of stay on either side of the IPPS threshold. Analysis of payment data in MedPAR suggest the average payment reduction under this policy for cases within two days of meeting the IPPS comparable threshold would be over $3,000. This difference is dramatic when considering that a majority of SSO cases are paid for at 100% of cost. In fact, almost half (46%) of the savings from this policy change would come from cases with a LOS within two days of the IPPS comparable threshold. (Table 5)

The policy would create an even larger payment cliff for patients with a LOS longer than 20 days (but below the IPPS threshold). MedPAR data indicate that the average payment reduction for the 350 VSSO cases with a LOS over 20 days would be over $5,000. For longer stay cases to face higher reductions in payments than short stay cases goes against CMS's goal for implementing this policy, which is to decrease incentives for LTACHs to admit very-short-stay patients. The policy would institute a larger payment penalty for stays over 20 days, which contradicts CMS's stated goal for discussing this payment option. Implementing this policy creates strange incentives for LTACHs because it would put them at greater financial risk when taking patients with relatively long stays. If CMS intends to create incentives for LTACHs to admit only patients with long stays, this policy would go against that incentive.

Table 5



Source: MedPAR 2005

CMS's SSO policy has another perverse effect: it results in additional payment cuts for the most medically complex LTACH patients that reach high cost outlier status. This is because overall LTACH payment reductions such as the SSO provision raises the financial stop loss threshold that LTACHs must incur before receiving high cost outlier payments since the LTACH payment methodology limits high cost outlier payments to 8% of total LTACH payments. Consequently, CMS not only fails to target payment adjustments to "very short stay" cases, the proposed policy also penalizes LTACHs who treat the longest stay, most medically complex and expensive to treat patients.

g. The Proposed Rule Defies the Basic Premise of LTACH PPS

Basing LTACH payment on IPPS per diem rates violates the statutory requirement that CMS reimburse LTACHs on a per discharge basis that reflects the differences in patient resources and costs for hospitals having an average length of stay of greater than 25 days. The statutory definition of an LTACH, the statutory directive for an LTACH PPS, and the entire framework of the LTACH PPS are based upon reimbursing LTACHs for Medicare inpatients who ***on average and in the aggregate*** have a length of stay of greater than 25 days. The policy CMS is proposing, as with prior SSO policies, violates this cornerstone of LTACH reimbursement law and erodes the PPS.

3. Kindred Position and Alternatives

CMS should wait until data is available to evaluate the effectiveness of its SSO policy changes from last year before making this or any further changes. Kindred strongly encourages CMS to delay further changes in the SSO policy until after reviewing relevant data and proposing specific regulatory language. To date, CMS has produced no study or analysis showing that inappropriate admissions constitute a material portion of SSO cases and, to the contrary, the data presented above demonstrates that SSO cases are, in fact, appropriate for admission to LTACHs.

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. CMS should be well aware that the rate of payment for these cases will be insufficient to cover LTACHs' reasonable and necessary costs in providing care to SSO patients. Furthermore, the proposed policy violates the statutory requirement that CMS reimburse LTACHs on a per discharge basis that reflects the reasonable and necessary cost of providing services in a hospital having an average length of stay of greater than 25 days.

C. Market Basket Increase and Overall Payment Adequacy

1. Summary of Proposal

For FY 2008, CMS estimates that the market basket increase from July 1, 2007 to June 30, 2008 will be 3.2%. After an adjustment to account for the increase in case-mix in FY 2005 of 2.49%, CMS proposes to update the standard Federal rate by 0.71% for FY 2008. As a result, the Federal rate for FY 2008 will equal $38,356.45, unless the final Federal rate for FY 2008 is updated in the final rule based on more recent data. CMS explicitly retained the ability to update to the standard Federal rate in the final rule. Furthermore, CMS offers to consider other data sources that could be used to determine a proxy for "real" LTACH PPS case-mix change, other than the 1.0 to 1.4% per year case-mix parameters based on a study by RAND. The "real" case-mix index increase is defined as the increase in the average LTC-DRG relative weights resulting from the hospital's treatment of more resource intensive patients. CMS contends that changes in the case-mix index result from a combination of "real" changes and "apparent" changes. Apparent changes are defined as increases in the cost-mix index due entirely to changes in coding practices. In order to limit what CMS considers are apparent changes to the case-mix index, CMS is soliciting comments on other date sources for determining the change in the real case mix.

2. Kindred Response

a. LTACH Margins Demonstrate that a 0.7% Increase in the Standard Federal Rate Is Inadequate.

In recent years, CMS has made numerous changes to LTACH PPS that have slowed growth in new LTACHs and controlled margins. In addition to the existing 25% rule, CMS reweighted the DRGs in October of 2005 and again in October of 2006, the former causing a 4.2% reduction in rates and the latter causing a 1.4% reduction in rates. Effective July of 2006, CMS reduced payment to short stay outliers by 3.7% and made no increase in the market basket update. The proposed rule is estimated to further decrease SSO payments another 0.9%. The cumulative effect of these payment changes has been to bring LTACH margins close to zero. Based upon MedPAC's margin analysis, CMS is proposing rates below LTACH providers' cost of care. Without even considering the cumulative effect of the proposed changes, MedPAC estimates margins of 0.1% to 1.9% for LTACHs.[7]

In the proposed rule, CMS states that under the proposed changes (*i.e.* VSSO payment reduction, reduced market basket update of 0.71%, and payments based on the inpatient PPS for admissions exceeding 25% from a single referral source) that payments will be adequate. However, detailed analysis of expected LTACH margins under these proposed payment rules indicates that CMS is proposing inadequate payment rates to LTACHs. In order to determine the impact of the proposed changes, Kindred evaluated the proposed policy changes using the CMS impact analysis table to calculate margins for RY 2008. In addition to the policies for which CMS published an estimated impact, Kindred also calculated an estimated impact for the change in the high cost outlier ("HCO") fixed-loss threshold. Using MedPAC estimated margins for FY 2007 as a base for comparison, Kindred estimates that margins for RY 2008 would be negative 3.7% to negative 5.7%. See Table 6 below. Kindred strongly disagrees that payments to LTACHs under the rates proposed by CMS will be adequate. Our analysis shows that the cumulative impact of changes to LTACH PPS is so dramatic as to make the payment levels unsustainable.

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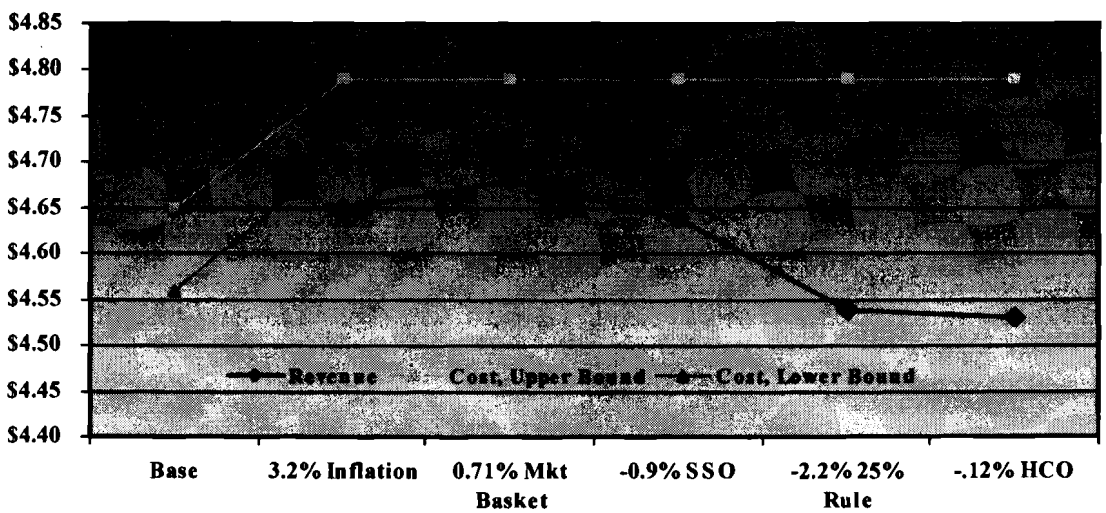
7 We acknowledge that MedPAC recommended a zero market basket update recommendation for LTACHs for RY 2008 but make the following points. First, MedPAC's recommendation did not contemplate the payment changes proposed by CMS that would bring LTACH payments well below costs. Second, we disagree with MedPAC's recommendation and believe it was based on incorrect data and assumptions about LTACH growth and LTACH's ability to maintain margin in the wake of past CMS payment changes.

Table 6

Base Estimate			$4.65	$4.65	$4.56
Proposed Policies					
Market Basket	0.71%		$4.68	$4.65	$4.56
Short-Stay Outlier	-0.9%		$4.64	$4.65	$4.56
Expansion of 25% Rule	-2.2%		$4.54	$4.65	$4.56
HCO Fixed-Loss Threshold	-0.12%		$4.53	$4.65	$4.56
Price Inflation		3.2%	$4.53	$4.79	$4.71
Margin				**-5.7%**	**-3.7%**

Using the CMS base revenue estimate of $4.65 billion for RY 2008, we estimate two cost levels (upper bounds and lower bounds) to account for both margin scenarios. Table 7 shows that the cumulative effect of changes in LTACH PPS is to reduce reimbursement below even the lowest estimate of costs.

Table7



A fundamental premise of the Medicare program and its payment systems is that Medicare should not knowingly reimburse providers and suppliers below the cost of care. This premise is reflected in the budget neutrality requirement that Congress established for the LTACH PPS. As CMS repeatedly acknowledged in the preamble to the final rule implementing the LTACH PPS, Section 1886(e)(1)(B) of the SSA [42 U.S.C. 1395ww(e)(1)(B)] requires the Secretary to maintain budget neutrality by ensuring that "aggregate payment amounts [under the PSS] are not greater or less than "the payment amounts which would have been payable for such services for those same hospitals for that fiscal year under this section under the law as in effect before the date of enactment of the Social

Security Amendments of 1983." See 67 Fed. Reg. 56027 ("Section 123(a)(1) of Public Law 106–113 [Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA)] requires that the prospective payment system for LTCHs maintain budget neutrality."); 67 Fed. Reg. at 56036 ("As we discussed in the proposed rule, consistent with the statutory requirement for budget neutrality, we intend for estimated aggregate payments under the LTCH prospective payment system to equal the estimated aggregate payments that would be made if the LTCH prospective payment system would not be implemented."); 67 Fed. Reg. at 56046 ("Consistent with the statutory requirement for budget neutrality, we intend for estimated aggregate payments under the LTCH prospective payment system to equal the estimated aggregate payments that would be made if the LTCH prospective payment system were not implemented.") Contrary to this premise, CMS now proposes a set of policies that would reduce LTACH margins for RY 2008 from a negative 3.7% to negative 5.7%. Kindred is greatly concerned that the proposed rule violates this premise, and perhaps the underpinnings of Medicare provider agreements with LTACHs, to knowingly reimburse LTACHs below cost. Further, as CMS acknowledges, the goal of prospective payment per discharge reimbursement is to encourage providers to treat patients efficiently, see 67 Fed. Reg. at 55999, not force them to provide substandard quality care or drive them out of business.

b. The Purpose of the Market Basket Increase Is to Account for the Expected Increases in Price Inputs for the Upcoming Year.

The market basket increase is designed to address increases in the cost of goods and services required to deliver LTACH services. Case-mix is only one element that might influence the price of inputs; other elements include increases in wages, drugs, products, supplies, etc. In proposing a 0.71% increase, CMS has not considered these other elements of the market basket. Changes in case-mix dominate the method used by CMS to propose an update to the market basket, even though case-mix has little to do with price inputs that comprise the market basket. This position conflicts with CMS's statements in connection with its proposal to annually reweight the LTC-DRGs in a budget neutral manner, where CMS makes clear that so-called apparent case-mix is no longer a concern.

The regulations do not contemplate changes in the case-mix as determinative of an appropriate market basket increase. Basing the market basket almost entirely on changes to the case-mix in prior years is an improper method of updating the standard Federal rate.

c. There Is No Basis for Offsetting Market Basket Increase with Case-Mix Increase of Prior Years.

In the proposed rule, CMS states that the reason for proposing a reduction in the market basket update is to account for "apparent" case-mix increases in previous years. CMS defines "apparent" case-mix increases as that portion of the total increase in the case-mix index due to changes in coding practices. No where in the code of Federal regulation does CMS state that a function of the market basket is to account for changes in case-mix attributable to "apparent" case-mix or state that the standard Federal rate may be adjusted for "apparent" case-mix. At § 412.523 CMS lists adjustments it may make to the standard Federal rate, including adjustments for outlier payments, budget neutrality during the transition, and a one-time budget neutrality adjustment. Case-mix changes are not included. Furthermore, there is no basis for reducing the case-mix increase based on claims data of FY 2004 and FY 2005. Other than the availability of data, CMS provides no logical explanation as to why an estimation of the "apparent" increase in case-mix derived from FY 2004 and FY 2005 claims should be applied to the market basket increase for RY 2008. This data has no relevance to changes in the price of LTACH services.

d. CMS Has Not Provided Verifiable Data to Support the Assumption of "Apparent" Case-Mix.

Kindred believes that CMS has not explained adequately how case-mix changes are related to changes in the price of inputs measured by the market basket update and, therefore, Kindred believes this proposal is not justified. The market basket update is a prospective measure of price inflation, and CMS provides no data suggesting that prices will not increase by 3.2% over RY 2008. CMS also does not provide any data showing that prices from 2004 to 2005 and from 2005 to 2006 (years included in the agency's case-mix analysis) increased less than the market basket update amount for those years. Considering CMS's definition of how the market basket update is calculated and applied to adjust the standard Federal rate, it is not appropriate to reduce the market basket update to account for changes in case-mix. Kindred supports a full market basket update for RY 2008.

In its March 2007 "Report to the Congress: Medicare Payment Policy," MedPAC states that the LTACH Medicare margin range for FY 2007 is expected to be between 0.1% and 1.9%. MedPAC calculates the Medicare margin by subtracting Medicare costs from Medicare revenues and dividing by Medicare revenues. Holding volume of services constant, if Medicare costs (price) increase by 3.2% as CMS estimates, and revenues do not increase similarly because of the reduced market basket update CMS proposes, then Medicare margins would become negative through this proposal alone. Other CMS proposals included in this regulation would lower Medicare margins further. Kindred estimates that the LTACH industry Medicare margin would be negative 3.7% and negative 5.7% for RY 2008.

e. Without Verifiable Data to Support Its Assumption of "Apparent" Case-Mix, CMS Is Applying an Unpredictable Method for Calculating the LTACH Market Basket Increase.

CMS does not base the proposed update to the standard Federal rate on verifiable or relevant data. The update factor of 0.7 is calculated by subtracting the "observed" increase in the case-mix (3.49%) from the estimated increase in the market basket (3.2%) and then adding back what CMS deems the "real" case-mix increase (1.0%). To find the "real" case-mix increase, or the portion of the case-mix increase CMS attributes to an increase in treatment of resource intensive cases, CMS relies on the estimate of real case-mix increase based on a study of acute care hospitals published in 1991 and conducted on claim data from 1987 to 1988. CMS fails to explain how this old data is relevant to a different provider-type, especially a provider with a smaller subset of frequently used DRGs. Furthermore, CMS opted to accept the more conservative increase in case-mix (1.0%), rather than the upper bound of the RAND study (1.4%). CMS provides no justification for this choice.

While updating the market basket increase to account for unmeasured changes in coding practices, CMS simultaneously requests "comments on other data sources that could be used to determine a proxy for real LTCH PPS case-mix changes other than the 1.0 to 1.4 percent per year case-mix parameters based on the RAND study." 72 Fed. Reg. 4,792. "We believe that there is still ***some*** component of apparent CMI increase within the observed CMI increase of 3.49 percent that is due to coding practices rather than the treatment of more resource intensive patients." 72 Fed. Reg. 4,791. From CMS's own comments, it is clear that CMS has no confidence in the accuracy or relevance of the estimated case-mix, yet this estimate has a substantial impact on the proposed market basket increase. Kindred believes it is inappropriate to offset the increase in the market basket based on an unpredictable method of calculating the case-mix.

f. An Adjustment in the Market Basket Due to an "Apparent" Case-Mix Increase Is Inconsistent with CMS's Proposal to Implement Budget Neutral Reweighting of LTC-DRG.

In determining the proposed update to the standard Federal rate for RY 2008, CMS adjusted the market basket update to reflect a belief that "some" component of the case mix increase is due to coding practices, rather than the treatment of more resource intensive patients. In the discussion of the market basket increase, CMS claims that the "apparent" case mix adjustment is necessary to protect "the integrity of the Medicare Trust Funds by ensuring that the LTCH PPS payment rates better reflect the true costs of treating LTCH patients." 72 Fed. Reg. 4,792.

It is inconsistent and punitive to offset the market basket increase based on case-mix increases in prior years. CMS must account for the increase in price inputs that raise the cost of resources LTACHs use in providing care to Medicare patients. If CMS is concerned with improper coding of services, the proper course of action is for QIOs to review claims data and address specific instances of abuse. Instead, CMS is assuming that the entire LTACH provider community has abused the payment system and, therefore, should receive a reduction in payment based on past coding practices.

g. The Proposed Market Basket Update Does Not Consider the Impact of the Increase in the High Cost Outlier Threshold.

CMS is not considering all of its payment adjustments in proposing new policy changes, including the market basket adjustment. For example, CMS has not taken into consideration the impact of the increase in the high cost outlier threshold. CMS proposes to increase the HCO fixed loss threshold from $14,887 to $18,774 for RY 2008. This proposal increases the amount of costs for which the LTACH provider is not reimbursed by $3,887 before the case qualifies as a HCO case. The LTACH provider is reimbursed for 80% of the costs that exceed the $18,774 threshold. Analysis of the distribution of Medicare payments for HCOs using 2005 MedPAR data, adjusted to reflect the RY 2008 proposed fixed-loss amount, indicate that if the fixed loss threshold is increased by $3,887, 26% of cases would no longer meet the HCO threshold. Kindred believes that reducing access to HCO payments for this many cases is not warranted, especially in an environment where CMS proposes to pay for so many cases below cost.

3. Kindred Position and Alternatives

CMS should provide the full market basket update of 3.2% for RY 2008. An increase of less than the market basket will not account for the cost of goods and services required to deliver LTACH services and will result in rates below the cost of care. As proposed, the market basket increase will be offset by a factor that is not relevant to the price of inputs generally or specifically the cost of providing LTACH services in RY 2008. The full market basket update is a more accurate reflection of items and services purchased to treat Medicare beneficiaries and is necessary to account for the rising cost of inputs.

D. One-Time Budget Neutrality Adjustment

1. Summary of Proposal

Under existing rules, CMS provided for the possibility of making a one-time prospective adjustment to the LTACH PPS rates before the end of the transition period (originally October 1, 2006, now July 1, 2008) to correct any error CMS made in estimating the federal rate in the first year of LTACH PPS. In the proposed rule, CMS delays the decision of whether to exercise the one-time prospective budget neutrality adjustment. CMS asserts that it will have sufficient new data for a comprehensive reevaluation of the FY 2003 budget neutrality calculations after October 1, 2007, the

conclusion of the five year transition period. Accordingly, CMS proposes to again consider whether to make a one-time prospective adjustment to the LTACH PPS rates for RY 2009.

2. Kindred Response

All of the payment adjustments CMS has made to the LTACH PPS since it was effective on October 1, 2002 offset the need for a one-time budget neutrality adjustment. In the preamble to the final rule implementing LTACH PPS, CMS reasoned that the one-time budget neutrality adjustment was necessary to ensure that aggregate payment under LTACH PPS would equal approximately the amount that would have been paid to LTACHs under TEFRA had LTACH PPS not been implemented.

Since the LTACH PPS began on October 1, 2002, CMS has used a variety of adjustments to the federal rate to reduce payment. In addition to the existing 25% rule, CMS reweighted the DRGs in October of 2005 reducing rates by 4.2% and again reweighting DRGs in October of 2006 causing a 1.4% reduction in rates. Effective July of 2006, CMS reduced payment to short stay outliers by 3.7% and made no increase in the market basket update. The proposed rule is estimated to further decrease SSO payments by another 0.9%. The cumulative effect of these payment changes has been to bring LTACH margins close to zero. Based upon MedPAC's current margin analysis, CMS is now proposing rates from 3.8% to 5.7% below LTACH providers' cost of care if the proposed rule is finalized in its current form (see Table X). Taken together, these adjustments ensure that any difference between actual payments and estimated payments for the first year of LTACH PPS have not perpetuated. There is no need for a one-time budget neutrality adjustment. In our view, the series of adjustments to LTACH PPS rates in recent years offsets any estimated "overpayment" in first year LTACH PPS rates that CMS may feel the need to correct with a one-time adjustment.

3. Kindred Position and Alternatives

Kindred agrees that CMS should not make the one-time budget neutrality adjustment at this time, and believes the data supports not making this adjustment in the future. Significant adjustments have been made to LTACH PPS since it was implemented on October 1, 2002. The cumulative effect of these policy changes negates the need to correct any discrepancy between estimated and actual payments in the first year of the LTACH PPS. At a minimum, CMS should treat as offsets the numerous payment reductions should it consider imposing the one-time budget neutrality adjustment in the future.

E. Budget-Neutral Reweighting of LTC-DRGs

1. Summary of Proposal

Beginning with the LTC-DRG update for FY 2008, CMS proposes to make an annual update to the recalibration of the LTC-DRG relative weights that would have a budget neutral impact so that the estimated aggregate LTACH PPS payments would be unaffected. CMS would update the LTC-DRG weights annually in the IPPS rulemaking and those weights would be modified by a single budget neutrality adjustment factor to ensure that estimated aggregate LTACH payments after reweighting are equal to estimated aggregate LTACH payments before reweighting.

2. Kindred Response

Kindred supports CMS's proposal to establish a budget neutral requirement for the annual reclassification of the LTC-DRGs and recalibration of relative weights. Furthermore, the annual re-weighting of DRGs in a budget neutral manner is explicitly designed to redistribute weights in such a way as to address "real" or "apparent" changes in case-mix. Kindred urges CMS to use budget neutral DRG re-weighting, not market basket reductions, to address this issue. To further ensure proper payment for resource intensive cases, CMS should monitor the annual reweighting of LTC-DRGs to

determine if the reclassification and recalibration directs payments from high acuity to lower acuity DRGs. Any reweighting of LTC-DRGs should be conducted in a manner that does not result in a redistribution of payments from high acuity DRGs to lower acuity DRGs, pending implementation of revised certification criteria designed to screen out LTACH inappropriate patients.

3. Kindred Position and Alternatives

Kindred supports this change in policy as a necessary step to bring the LTACH PPS more in line with the IPPS budget neutrality requirements. Kindred has advocated budget neutral reweighting in the past. It is also included in the bills before the United States House of Representatives (H.R. 562) and Senate (S. 338).

F. Reconciliation of Outlier Payments Upon Cost Report Settlement

1. Summary of Proposal

LTACHs are reimbursed 80% of cost for cases that reach high cost outlier status. Certain short stay outlier cases are also reimbursed at 100% of cost. In both computations, the cost-to-charge ratio (CCR) is used in determining the amount of reimbursement for each case. The CCR is calculated using information obtained from a prior period Medicare cost report.

CMS enacted provisions in the regulations at 42 CFR 412.525 and 42 CFR 412.529 to provide for a reconciliation of these outlier payments to LTACHs. Essentially, if the CCR that is used in the payment calculation for outliers varies by more than 10 percentage points from the CCR of the cost report period in which the outlier patient was discharged, then CMS can retroactively adjust prior outlier payments made to the hospital using the more current CCR. No changes are being proposed to either regulation at this time.

2. Kindred Response

In general, Kindred supports the process defined by CMS to reconcile outlier payments. These provisions were added to halt the abuse of certain previously existing regulations that provided guidance on the payment of outliers to STACHs. However, there is an unintended consequence of the current regulations governing the outlier reconciliation process.

Hospitals in New Orleans, Louisiana, suffered devastating consequences as a result of the destruction caused by Hurricane Katrina on August 29, 2005. These facilities experienced a significant decline in volume and conversely an increase in costs associated with the recovery. The result was that hospitals in this region saw an increase in their CCRs for the cost report period immediately following the hurricane. This spike in the CCR is an anomaly created by this event. As CCRs return to a more normal level in the second post-Katrina cost report, some hospitals will be required to refund outlier reimbursement to CMS as a result of the retroactive provisions of the reconciliation process. This repayment occurs because the CCR in the second post-Katrina cost report is more than 10 percentage points lower than the CCR being used in the formula to that determined the initial payment for these outlier cases. The CCR used in the initial payment of outliers is based on the 2006, or first post-Katrina, cost report.

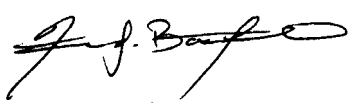
3. Kindred Position and Alternatives

Kindred advocates an exception to the outlier payment reconciliation requirements for hospitals that have been adversely affected by Hurricane Katrina. Hospitals that experience such an aberrant change in their CCR during the first or second cost reporting periods that began on or after August 29, 2005, should be exempted from having a retroactive adjustment made to outlier payments. These hospitals suffered a tremendous catastrophe and should not be burdened further with repaying the Medicare program because of issues beyond their control.

II. Conclusion

We strongly suggest that CMS consider the data and analyses that we have provided in these comments. It is apparent that the growth of LTACHs has been checked by the 25% limit placed on HIHs in 2004, that the SSO payment and other policies enacted in 2006 have helped to push LTACH margins to near or below zero, and that many cases will be paid below cost if the proposed changes are enacted. Additionally, should CMS not withdraw its proposal to expand the 25% policy, Kindred urges that serious consideration be given to protecting existing LTACHs by grandfathering these facilities. Kindred endorses the comments submitted by the Acute Long Term Hospital Association (ALTHA) and looks forward to working with CMS and ALTHA on a more effective set of proposals to better define the patients and setting for long-term acute hospital care.

Sincerely,



Frank J. Battafarano
President, Kindred Healthcare Hospital Division

Submitter : Dr. Russell MaIER **Date:** 03/26/2007

Organization : Central Washington Family Medicine Residency

Category : Physician

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

Letter on CMS proposed 90% calculation
3/26/07

Representing seventeen family medicine residency programs in the Northwest spanning five states (Washington, Wyoming, Alaska, Montana and Idaho), we are writing to adamantly oppose this proposal: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes.

Family medicine training in our region regularly occurs in the community. We rely heavily on preceptors in the community to help train residents to be the kind of doctors that are needed in the largely rural areas of these five states in the Northwest.

Here are six critical points that we, as a consortium of 17 Family Medicine Residency programs, would like to make clear in our argument against this proposal:

1. We appreciate CMS's effort to define "All Substantially All" to a threshold of 90 %. However that threshold is still too high and needs to be reduced to 75 %.

2. CMS should allow for physician volunteerism that most if not all of our community physicians provide.

3. CMS should allow programs / hospitals to exclude the costs of teaching physicians as part of the definition of "all or substantially all".

4. We recommend the 3 hour of non clinical didactic time be dropped to 1 hour per week as this most closely fits with the reality of this time in community preceptors offices. If the 3 hour non-clinical didactic per week rule is used then that should be prorated for the number of clinics that the residents have with the preceptor per week (for example many of our residents come back to the residency for their weekly clinics).

5. Hospitals / programs that are over their cap on residency slots as determined by BBA or BBRA have no duty to fulfill the requirements of this rule as the Medicare program is not paying for such training.

6. CMS has and will continue to adversely effect Family Medicine programs ability to train Family Physicians in community programs by having overly burdensome and onerous requirements for the use of community preceptors, none of whom see this as a problem.

In summary, the proposed policy would make training in the community difficult or impossible for most of our programs. This negative result is the opposite of what is needed to train family physicians for community practice.

Submitter : Dr. Kevin Murray **Date:** 03/26/2007

Organization : Univ of Wash Family Medicine Residency Network

Category : Academic

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

Representing seventeen family medicine residency programs in the Northwest spanning five states (Washington, Wyoming, Alaska, Montana and Idaho), we are writing to adamantly oppose this proposal: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes.

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In summary, the proposed policy would make training in the community difficult or impossible for most of our programs. This negative result is the opposite of what is needed to train family physicians for community practice.

Sincerely,

Kevin Murray, MD
President, UW Family Medicine Residency Network
Director, Tacoma Family Medicine

CMS-1529-P-105-Attach-1.PDF

#105

UW Medicine
SCHOOL OF MEDICINE

Dept of Family Medicine

Residency Network

Box 354696

Seattle, WA 98195-4696

Tel: (206) 685-1856

Fax: (206) 685-8963

March 26, 2007

RE: CMS proposed 90% calculation

To Whom It May Concern:

Representing seventeen family medicine residency programs in the Northwest spanning five states (Washington, Wyoming, Alaska, Montana and Idaho), **we are writing to adamantly oppose this proposal**: *Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes.*

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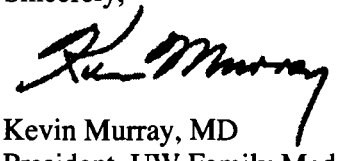
In summary, the proposed policy would make training in the community difficult or impossible for most of our programs. This negative result is the opposite of what is needed to train family physicians for community practice.

Sincerely,



Kevin Murray, MD
President, UW Family Medicine Residency Network
Director, Tacoma Family Medicine

Submitter : Dr. William Hester **Date:** 03/26/2007

Organization : McLeod Family Medicine Residency Program

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

For so long, CMS encouraged primary care training programs to utilize ambulatory practice sites for teaching. Now you wish to punish us for following your urgings.

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

Payment for non-hospital teaching site physicians who train our family medicine residents is proposed for final rule. Non-hospital site physicians have always been volunteer teachers. On my faculty, that is the way they wish to stay. Our program conducted a very detailed survey as to how much "teaching" is done at these sites. Any discussion about patients, medical issues, etc that was linked to a patient for which the teaching physician would submit a bill was elinimated from the survey. Our residents were abundantly clear on why this was necessary. The residents then for a period of several days kept an average amount of time spent with the teaching physician in which there was didatic teaching NOT linked to a perfossional bill. The amount of time documented NEVER approached the "3 hours per week as a prusumptive standard number of hours that a teaching physician spends in nonpatient care GME activities at a particular nonhospital site". Frequently the teaching time defined properly never even approached one (1) hour/week. Most teaching that occurs in non-hospital sites is the same as that in hospital sites and is patient related and connected. Trying to establish a threshold of "3 hours per week" would be very difficult for our staff and that of the teaching physician to assure to CMS of accuracy in reporting. Our schedule is based on 13 (4) week blocks of training for a 7-7-7 resident program which amounts to 273 rotations/year, 48.5 rotations (18%) are spent in non-hospital settings.

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

Not only would this be a tremendous financial impact on our program and would come at a time when hospitals are beginning to review what they already contribute to graduate medical education, it would institute an administrative nightmare for our accounting/clerical staff, not only in the residency program but in the non-hospital site as well. (My high school English teacher would be appalled at this last sentence!)

Submitter : Mr. Ebbie Erzuah **Date:** 03/26/2007

Organization : Edward W. Sparrow Hospital Association

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1529-P-107-Attach-1.DOC

#107

SPARROW
WORKING WONDERS℠

March 21, 2007

[VIA ELECTRONIC FILING]

Leslie V. Norwalk, Esq.
Centers for Medicare and Medicaid Services
Department of Health and Human Services
ATTN: CMS – 1529-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-1529-P-Medicare Program: Payment For Direct Graduate Medical Education: Proposed Rule, February 1, 2007 Federal Register

Dear Ms. Norwalk:

On behalf of Sparrow Hospital, we wish to take this opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Proposed Rule on the Payment For Direct Graduate Medical Education published in the February 1, 2007 Federal Register.

As part of comments on the Payment for Direct Graduate Medical Education proposed rule, it is our belief that the adequacy of Medicare payments, to cover the cost of medical education, is crucial for ensuring the future viability of the country's, and Michigan's, teaching hospitals. Medical advancements and the professionalism of physicians in the United States is the best in the world because of the quality training medical residents/students receive within the current teaching hospitals and government partnership. Teaching hospitals, teaching physicians and the government (State and Federal) benefit greatly from this partnership because no single entity bears the total financial burden of training the next generation of health care providers. The proposed regulation on payment for direct graduate medical education would greatly threaten the current private sector and government partnership when it comes to funding and training residents.

In 2005 the direct operating cost of the Sparrow Medical Education Department was $12 million while Medicare DGME payments was only $5.4 million; a shortfall of $6.6 million. When fixed overhead (benefits, depreciation and utilities) is added to the direct operating cost of the department, the total cost of running the Medical Education Program at Sparrow Hospital increases to $19 million; which increases the total shortfall to $13.6 million. Medicaid medical education payments of about $4.6 million reduce the shortfall to $9 million.

Therefore, the following comments are offered in an effort to assist CMS in modifying the Payment for Direct Graduate Medical Education Proposed Rules in order to mitigate potential negative impact of rule on teaching hospitals, such as Sparrow Hospital.

"Payment For Direct Medical Education" (Federal Register Page 4818)

In the February 1, 2007 Proposed Hospital Direct and Indirect Graduate Medical Education policy changes, CMS provided guidance on resident training in non-hospital settings reimbursement. Section 1886(h)(4)(E) of the Act requires that the HHS Secretary's rules concerning computation of FTE residents for purposes of direct GME payments "provide that only time spent in activities relating to patient care shall be counted and that all time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed if the hospital incurs all, or substantially all, of the cost for the training program in that setting".

This rule has applied to all direct GME payments since July 1, 1987. Section 4621(b)(2) of the BBA revised Section 1886(d)(5)(B) of the Act to allow providers to count time residents spend training in non-provider sites for IME purposes, effective for discharges occurring on or after October 1, 1997. Unfortunately, Section 1886(h)(4)(h) of the Act established limits on the number of allopathic and osteopathic residents that a hospital may count for purposes of calculating direct GME and IME reimbursement as of the most recent cost reporting period ending on or before December 31, 1996. **Teaching hospitals like Sparrow did not benefit from the expansion of the non-provider training provision for IME purposes under Section 1886(d)(5)(B) because of the establishment of IME FTE limits as of the most recent cost reporting period ending on or before December 31, 1996.**

Section 413.75(b) of the July 31, 1998 final IPPS rule redefined "all or substantially all of the costs for the training program in the non-hospital setting" as the residents' salaries and fringe benefits (including travel and lodging where applicable), and the portion of the of the cost of teaching physicians' salaries and fringe benefits attributable to direct GME. This definition is appropriate if you start with the premise that hospitals are making a substantial return on investment on their medical education programs. As stated above, Sparrow Hospital's Medical education program earned a negative return of $13.6 million in FY 2005. Sparrow is willing to lose or invest this substantial amount of money in the resident education program because of the non-fiduciary benefits that the hospital receives in having the residents on campus - such as:

- **The training of future physicians who may practice at Sparrow upon graduation.**

- **Prestige associated in being a teaching hospital.**
- **The intellectual curiosity that residents bring to the practice of Medicine.**

Supervisory teaching physicians have been willing to "volunteer" their time because they attain the same non-fiduciary benefits that teaching hospitals get in having the medical residents on site. The residents also perform management and evaluation services at the clinics as part of their training, thus reducing the time teaching physicians spend in the evaluation of patients.

In the February 1, 2007 proposed Graduate Medical Education Payment rule the CMS has developed a new definition of "all or substantially all of the costs for the training program at non-hospital setting" by allowing a teaching physician to attest that at least 90 percent of the teaching physician's GME time is spent in patient care activities. Providers would therefore be required to pay 90 percent of the GME cost of a training program in a non-hospital site. According to CMS the 90 percent proposal would be beneficial to hospitals since the CMS is no longer going to be requiring that hospitals pay 100 percent of the cost. The formula for determining the 90 percent threshold, or minimum amount that a hospital must pay for the GME costs of a particular program at a particular non-hospital site is:

0.90 x [(sum of each FTE resident's salary + fringe benefits (including travel and lodging where applicable)) plus the portion of the teaching physician's compensation attributable to direct GME activities.]

The teaching compensation portion attributable to direct GME activities may be calculated as follows:

(3/number of hours non-hospital site is open per week) x (national average salary for each teaching physician)

We would also like to state that Sparrow Hospital provides other payments to teaching physicians that are not listed as part of the CMS recommended compensation. For example Sparrow provides the following services to teaching physicians:

1. *Tracking, Reporting and documentation of CME credits*
2. *Teaching Physicians' Professional Memberships*

Non-teaching physicians do not receive the services listed above from the Sparrow Medical Education Department.

We had also hoped to see the fixed loss amount at least remain at the current level of $14,887. While we understand the complex mathematical calculations that must balance out all the payment factors in order to remain budget neutral, we hope that CMS could find a way to reward efficient LTCHs who are treating more medically complex patients and exceed the outlier threshold as a result.

We appreciate continued support of the DSH and IME factors in LTCH payment calculations.

We certainly appreciate that CMS has not yet instituted a one-time prospective adjustment to LTCH PPS rates in the 2008 year. We hope the data reviewed for the 2009 rate year will be the most recent available in order to most accurately reflect the cost of care delivered.

Other proposed policy changes for the 2008 LTCH PPS Rate Year

- Short stay outlier cases:

We agree that LTCH facilities should not receive full LTCH payment for short stay outlier (SSO) cases. Even when a patient exceeds the acute care DRG, IRFs and SNFs can continue care for non-medically complex patients who are not yet ready for discharge to home. We support all of CMS' proposed SSO payment methodologies, including the proposed alternate option, which would replace the existing blended option for SSO cases that fall within the "IPPS Comparable Threshold".

- 25% Rule

We appreciate the concern by CMS of LTCHs becoming "units" of acute care hospitals. We agree that HWH units and freestanding facilities should be subject to the same provisions in regard to "limitations" on admissions from any one facility. We also agree that "grand-fathered" facilities should be included in the facilities affected by this provision. We would like to propose, however, that CMS consider two alternatives to the proposed expansion of the 25% Rule to all LTCH facilities.

1. Raise the limit from 25% to 35%. We are a small facility in a small urban area in Northern Kentucky, and it is very difficult to stay within the 25% threshold for appropriate admissions. There are only 3 acute hospitals in the immediate area from which we receive most of our referrals. In addition, we do get referrals for Kentucky residents who have received their acute care in Cincinnati. Raising the threshold to 35% for any one facility would still allow CMS to achieve its goal while being more realistic for LTCH providers operating in a small urban market. These providers don't get the same 50% break that rural providers get, but function in similar market conditions as rural providers.

2. Eliminate the threshold for referrals to any LTCH from a level I trauma center or a University affiliated teaching hospital. These institutions tend to draw very medically complex patients from a wider geographic area than most other acute care hospitals. Neither those facilities nor LTCHs should be restricted from helping move these high cost, complex patients on to a post-acute level of care.

The admissions from those facilities should however, still be counted in the total calculation for the 35% threshold for admissions from other hospitals.

We do appreciate the fact that CMS is not recommending a change to the provision that allows for admissions of patients who have exceeded the high cost outlier threshold in acute care to not to be counted in this 25% Rule threshold calculation.

We also agree that this 25% Rule threshold should continue to be calculated on the basis of all admissions, not just Medicare admissions.

MedPac Recommendations: The RTI Contract

We would support the development of patient and facility level criteria to define an LTCH. The current criteria of having a length of stay exceeding 25 days is not an adequate measure of the LTCH's place in the post-acute care continuum. There are many acute rehabilitation hospitals which are designated as LTCHs, and this is an inappropriate use of CMS funds. These facilities should be designated as IRFs, and be subject to the same requirements as IRFs. Establishing patient level criteria which directs medically complex patients to LTCHs and rehabilitation patients to IRFs and SNFs is an appropriate modification to the LTCH PPS System.

We sincerely thank you for the opportunity to provide comments regarding this very important topic.

All the best,

Kerry G. Gillihan
President/CEO, FACHE

Submitter : **Mr. Robert Notarianni** **Date: 03/26/2007**

Organization : **Long Term Hospital of Anniston**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1529-P-109-Attach-1.DOC

#109

March 25, 2007

BY ELECTRONIC FILING

Hon. Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1529-P
Mail Stop C4-26-5
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: ***Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes; Proposed Rule, 72 Fed. Reg. 4776 (February 1, 2007)***

Dear Ms. Norwalk:

This letter presents comments and recommendations of Long Term Hospital of Anniston (LTHA) to certain aspects of the proposed annual payment rate updates and policy changes under the prospective payment system for long-term acute care hospitals ("LTACH PPS") for rate year ("RY") 2008, which were published by the Centers for Medicare & Medicaid Services ("CMS") on February 1, 2007.

LTHA is a not-for-profit 34 bed long term acute care hospital located in Anniston, Alabama, and is part of the not-for-profit health care system Noland Health Services (NHS) which is headquartered in Birmingham, Alabama. We employ more than 100 people and in our most recently completed fiscal year we admitted 370 patients to our facility.

LTHA is located within Northeast Alabama Regional Medical Center (NEARMC) which is a not-for-profit regional medical center serving a large portion of eastern and northeastern Alabama. NEARMC is the dominant Medicare provider in its service area.

LTHA is gravely concerned that the future of our not-for-profit mission will be jeopardized by CMS' continued focus on arbitrary and capricious reimbursement changes, rather than addressing a rationalization of the need for this very special level of care for the small segment of Medicare beneficiaries who require extended acute care.

LTHA opposes the arbitrary and inappropriate reductions in long-term care hospital ("LTACH") payments that will result if these proposed changes to the LTACH PPS are implemented. LTHA has reviewed the proposed rule and agrees with ALTHA that it suffers from a number of recurring problems. First, as with other recent rulemakings affecting LTACHs, CMS continues to rely upon materially flawed and incomplete data in developing their proposed changes to LTACH payments for RY 2008. Second, LTHA does not believe that CMS has seriously considered the legal and equitable issues which

this proposed rule raises with regard to patient freedom of choice, physician medical decision-making, and the disparate impact on LTACHs in underserved areas.

LTHA recommends that CMS reconsider its proposed changes to the LTACH PPS in light of the Medicare Payment Advisory Commission ("MedPAC") recommendations in June 2004 that the certification criteria for the Medicare LTACH provider category be strengthened to ensure that LTACH payments are being made to only those providers that are administering medically complex care to severely ill patients. LTHA supports this approach as a more defined method for limiting LTACH payments to hospitals that are truly caring for a medically complex patient population. Unfortunately, the proposals that CMS advances in this proposed rule continue to rely on arbitrary and unproven payment reductions to achieve policy goals that are, in many cases, compatible with more comprehensive LTACH certification criteria but will not achieve those goals and will significantly hinder the ability of our LTCH's to continue to provide quality patient care to Medicare beneficiaries.

Long Term Hospital of Anniston strongly believes that arbitrary payment reductions are the wrong approach if quality of care is to be encouraged.

First and foremost, CMS should reconsider its proposed policy for extending the so-called "25% rule" from hospitals-within-hospitals ("HIH's") to all LTACH's, and its proposed policy to enlarge the category of short-stay outlier ("SSO") cases. To the extent that CMS is concerned about "inappropriate" admissions to LTACH's, it should implement more appropriate non-payment approaches such as pre-admission physician certifications, uniform admission screening criteria, and more extensive Quality Improvement Organization ("QIO") reviews. 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, NHS supports that goal. 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. Moreover, the cumulative effect of these policies will result in significantly reduced and even negative operating margins in our not-for-profit LTACH's. Establishing payment policies that reimburse Medicare providers below the cost of care violates a basic premise of the Medicare program.

The proposed rule takes the next step in a series of apparently calculated efforts by CMS to reverse the growth in the number of LTACH's and reduce reimbursement to LTACH's for caring for Medicare beneficiaries suffering from complex medical conditions that require long hospital stays. In continuing to reduce payment rates and expose additional LTACH cases to payment rates for short-term acute care hospitals ("STACH's"), CMS fails to account for prior adjustments to the LTACH PPS in the past few years that have had a great deal to due with the lack of growth of new LTACH's in Alabama. CMS's own data shows that growth in the number of LTACH's has stopped. According to the December 2006 CMS Provider of Service file, there was a net reduction of one LTACH in 2006. With regard to margins, MedPAC estimated LTACH margins to be at or near zero even before the proposed rule was released. A comprehensive analysis of the proposed rule reveals that LTACH margins will be between negative 3.7% and negative 5.7% if the proposed policies are finalized. This reduction in payment significantly below the cost of providing care will dramatically impact the ability of all LTCH's, as well as NHS's, to provide quality services to Medicare beneficiaries. CMS should not engage in this type of punitive rulemaking when Congress has provided express statutory authority for LTACH's and a PPS that reasonably reimburses LTACH's for the cost of care.

In the preamble to the proposed rule, CMS offers one primary justification in support of its two most significant policy proposals to extend the so-called "25% rule" from HIH's to all LTACH's and to enlarge the category of SSO cases: its belief that LTACH's are acting like units of STACH's, such that it believes that patients admitted to LTACH's are continuing the same episode of care that began during the patient's stay in the referring STACH. However, CMS fails to provide credible evidence that these interrelated issues are, in fact, occurring. CMS's own independent consultant, RTI International, has stated that the issue of LTACH's offering a continuation of a single episode of care is "poorly understood." The *opposite* is true – STACH's are not discharging patients to our LTACH's "early" and

Medicare is *not* paying twice for a single episode of care. CMS's own data shows that LTACH patients have different characteristics than are evident during their preceding stay in a STACH. The data also shows that LTACH patients receive different treatments to address different clinical needs following a stay in a STACH. Furthermore, differences in the medical complexity and average length of stay of LTACH cases substantiate reimbursement at the LTACH PPS rate, not the inpatient PPS rate for STACH's. CMS also has not presented evidence that LTACH's are acting like units of general acute care hospitals. The existence of primary referral and discharge relationships between our LTACH's and STACH's are both required by law and necessary to facilitate quality patient care in the most appropriate patient care setting.

LTHA has serious concerns about a number of unintended consequences associated with CMS's proposal to expand the 25% rule to freestanding LTACH's and grandfathered LTACH HIH's and satellite facilities. CMS is proposing to expand the existing payment limitation threshold to any LTACH or satellite of an LTACH that discharges during a single cost reporting period more than 25% (or applicable percentage for rural, single-urban, or MSA-dominant hospitals) of Medicare patients admitted from any non-co-located individual hospital. The original 25% rule was adopted by CMS in regulations that were recently published on August 11, 2004 and have yet to be fully implemented. Until the existing 25% rule is fully implemented, it is impossible to know the full impact of the existing rule on LTACH's and the impact that rule is having on patient access and quality of care for Medicare beneficiaries. What we do know is that the existing 25% rule, in combination with CMS's other payment policies has reduced growth in the net number of new LTACH's to negative numbers. Yet CMS is advancing a policy that, without question, will further restrict patient choice and diminish access to quality care by imposing a rigid, arbitrary, and extremely limiting quota on the number patients who will be fairly reimbursed at the LTACH PPS rates.

Further, limitations on the number of patients admitted from a single hospital severely undermine physician judgment to determine what clinical setting is in the best interest of the patient. Through its other policies, CMS has repeatedly reinforced a patient's right to choose a health care provider. But this proposed policy will have a discriminatory impact on LTACH's and Medicare beneficiaries. For no clinical reason, patients in the 26th percentile and higher will be paid like general acute care patients when their complex medical needs and relatively long stays require LTACH care. The LTACH's that we operate that are located in underserved areas or communities with less than four general acute care hospitals where LTACH's lack the ability to offset reduced patient referrals from one hospital with a greater number of LTACH-level patients from other hospitals will be extremely negatively impacted by this rule. These results have nothing to do with the care required by a particular patient or the quality of care offered by a particular LTACH, and has everything to do with the unintended consequences that will result from the arbitrary nature of establishing a payment limitation that has no relevance to patient or facility level criteria. For these reasons, the proposed rule not only penalizes us and other LTACH providers, it penalizes all Medicare beneficiaries.

LTHA is concerned that CMS has set forth yet another proposal to expand the class of SSOs that would effectively be paid at STACH rates without understanding the types of patients that would be treated as SSOs under the proposed policy. In the proposed rule, CMS indicates that it is considering lowering LTACH payment to the IPPS rate for cases with a length of stay that is less than the average length of stay plus one standard deviation for the same DRG under IPPS. Cases with a covered length of stay less than or equal to one standard deviation for the same DRG under IPPS would be paid at an amount comparable to the IPPS per diem.

As noted above, CMS offers the same justification for this short stay policy as is offered for the 25% rule policy. CMS believes that LTACH patients with "very short" lengths of stay have not completed their "episode of care" and should not have left the STACH. CMS's own data provides no support for this "belief." Moreover, rather than capture truly short-stay patients with lengths of stay that approximate STACH patient lengths of stay, as suggested, this policy would actually have the perverse effect of treating as SSOs many LTACH patients with lengths of stay that approach the 25-day average

for LTACH certification (*e.g.*, 21 days, 23 days). LTHA strongly encourages CMS not to make further changes in the SSO policy based upon the data provided herein and because MedPAR data is not available yet to evaluate whether the SSO policy changes put into effect last year are achieving the desired policy goals. CMS has produced no study or analysis in the proposed rule showing that inappropriate admissions constitute a material portion of SSO cases. To the contrary, the opposite is true: SSO cases are, in fact, appropriate for admission to LTACH's for a number of reasons, including the fact that even shorter stay LTACH's patients are more severely ill than comparable STACH patients; difficulty in screening SSOs from admission to LTACH's based upon clinical criteria at the time of discharge from the referring hospital; the inability of clinicians to predict when LTACH patients will expire; and the inherent averaging of patient lengths of stay that is the foundation of the current LTACH certification criteria and PPS. If the patient meets InterQual admission criteria, and can be reasonable expected to stay for an extended period of time, and a physician admits the patient, the LTCH should not be so severely financially penalized that negative operating margins are created. 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. It would seem that CMS would be aware that the rate of payment for these cases will be insufficient to cover LTHA's and other LTCH's reasonable and necessary costs in providing care to this segment of LTACH patients.

The proposed policies violate the statutory requirement that CMS reimburse LTACH's on a per discharge basis that reflects the reasonable and necessary cost of providing services in a hospital having an *average* length of stay of greater than 25 days. The proposed policies will continue to erode the LTACH PPS by reimbursing LTACH's for fewer and fewer medically complex patients at the LTACH PPS rates. The LTACH PPS must adequately reimburse LTACH's for the costs they incur in caring for Medicare beneficiaries. The cumulative effect of the proposed changes to the LTACH PPS will be to bring LTACH reimbursement below the cost of care. This level of reimbursement is unsustainable and will inevitably result in a decrease in access to LTACH services in spite of the increasing number of Medicare beneficiaries and the overall aging of the country's population. The Congress, the LTACH industry, MedPAC, and RTI International all agree that LTACH's serve an important role in caring for medically complex patients who need long-term hospital stays. CMS should develop policies that reflect this consensus. We encourage CMS to work with the Congress to develop meaningful facility and patient certification criteria for LTACH's, as proposed in H.R. 562 and S. 338.

LYHA objects to CMS's proposal to provide less than the full market basket update of 3.2% for RY 2008. An increase of less than the market basket will not account for the cost of goods and services required to deliver LTACH services and will result in rates below the cost of care. The full market basket update is an accurate reflection of items and services purchased to treat Medicare beneficiaries and is necessary to account for the rising cost of inputs. The federal rate must be updated in accordance with the market basket to keep LTACH payment rates in step with the higher cost of price inputs.

In summary, LTHA urges CMS to carefully consider the comments and data provided in this letter and to reexamine the policies advanced in the proposed rule. The types of patients admitted to LTACH's, the care provided during an LTACH stay, and the relationships that LTACH's have with STACH's show that Medicare is not paying twice for a single episode of care. LTACHs serve a distinct and important purpose in the health care continuum. LTHA is vital to the mission of Noland Health Services, of meeting unmet healthcare needs for an underserved population in Alabama. CMS's payment policies should reflect this in a manner that fairly compensates LTACH's for the care they provide to thousands of Medicare beneficiaries in Alabama and across the nation.

Sincerely,

Robert G. Notarianni,
Administrator

Submitter : Mr. Lee Layne **Date:** 03/26/2007

Organization : Charleston Area Medical Center

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1529-P-110-Attach-1.DOC

Payment for Direct Graduate Medical Education

Comments:

#1 Supervisory teaching costs: If the non-hospital rotation is part of a weekly rotation such as one afternoon per week, then the supervising physician compensation should be annualized to the rotation. For example, if a resident spends one day per week at a non-hospital group practice, then the supervising physician's compensation along with the assumed administrative time of 3 hours should be annualized at a 20% rate. If the supervising physician's annual salary is $150,000 then only $30,000 should be used in the 90% "all or substantially all" calculation of the total teaching costs. Also, the 3-hour proxy for the administrative time should be annualized to arrive at 0.6 hour per week. These numbers would coincide with annualized salary and fringe costs for the resident. If this is not matched up, then the supervising teaching costs would be greatly overstated.

#2 3 hour administrative time proxy and overall clinic time: I would like to applaud CMS for trying to quantify administrative time the teaching physicians spend with residents at non-hospital group physician practices. This will alleviate having to go to the teaching physicians and requesting time studies. The teaching physicians would not have appreciated it and some would have dropped out having to comply with this requirement.

The 3-hour administrative time proxy will be the numerator in a fraction and the hours the non-hospital group physician clinic is open to the public will be the denominator in the fraction. You addressed the denominator in the proposed rule as being the clinic hours since it would be relatively easy to quantify. However, I feel this will greatly underestimate the numerator. We all know physicians work more hours than what their clinic is open to the public. The physicians may make rounds to the hospital to see patients when the clinic is closed. I would like to suggest adding another option to the numerator. If the physician were willing to attest in writing on their average hourly workweek, then this would be another method to use in the denominator. A more accurate administrative % would be calculated using this methodology.

If CMS chooses not to allow an attestation to the denominator of this fraction, I feel a reduction of the 3-hour administrative time proxy to 2 hours would suffice.

#3 Fringe benefit costs: Our hospital incurs the malpractice costs to the residents. We feel this is a fringe benefit that is not specifically mentioned in the proposed regulations. Since there are many fiscal intermediaries and each may have a different interpretation of what a fringe benefit is, I feel a specific mention of malpractice costs as being part of the fringe benefit calculation would be appropriate.

Submitter : Melissa Dehoff **Date:** 03/26/2007

Organization : The Hospital & Healthsystem Assn. of PA

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1529-P-111-Attach-1.DOC

#111

THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

March 26, 2007

The Honorable Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Attn: CMS-1529-P
P.O. Box 8015
Baltimore, MD 21244-8015

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, Policy Changes, and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes; Proposed Rule, (Fed. Reg. Vol. 72, No. 21), February 1, 2007.

Dear Ms. Norwalk:

On behalf of The Hospital & Healthsystem Association of Pennsylvania (HAP), which represents approximately 250 member institutions, including 125 stand-alone hospitals and another 120 hospitals that comprise 32 health systems across the state, we appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule concerning the long-term care hospital prospective payment system (LTCH PPS) for rate year (RY) 2008. Our comments focus on several significant changes in this proposed rule, including the proposed expansion of the 25 % Rule on patient referral source; changes to the short-stay outlier policy, and an offset for coding changes. HAP has concerns that this proposed rule contains policies of arbitrary cuts, rather than developing and establishing appropriate admission criteria for the patients that use the LTCH level of care. However, we are supportive of the move to re-weight the LTCH diagnosis-related groups (DRGs) in a budget-neutral manner.

Proposed Changes to LTCH PPS Payment Rates for the 2008 LTCH PPS Rate Year

Market Basket Increase and Payment Adequacy

CMS proposes to provide a less than full market basket update of 3.2 percent for RY 2008 based on the rehabilitation, psychiatric, and long-term care (RPL) market basket. In addition, CMS proposes to partially offset the 3.2 percent market basket update with a

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coding adjustment of negative 2.49 percent, which is intended to account for coding increases in fiscal year (FY) 2005. As a result, the federal rate for FY 2008 will equal $38,356.45, unless the final federal rate for FY 2008 is updated in the final rule based on more recent data.

For FY 2005, CMS calculated what they call a *total* case-mix index increase of 3.49 percent, which cited by CMS, is partially due to changes in coding behavior referred to as "*apparent* case-mix," and partially due to the increased cost of treating more resource intensive patients, called "*real* case mix." CMS based its projected growth in real case mix of 1.0 percent on experience and patterns in the general acute inpatient PPS. Therefore, for RY 2008, CMS is recommending a coding adjustment of negative 2.49 percent that reflects CMS' estimates of *total* case-mix index increase minus *real* case-mix index increase in FY 2005 (3.49 – 1.0 = 2.49). With CMS' proposed negative 2.49 percent coding adjustment, the actual RY 2008 update would be only 0.71 percent.

CMS should provide the full market basket update of 3.2 percent for updating LTCH payments in RY 2008. CMS' policies, during the last two years, have reduced LTCH payments by more than 7 percent. An increase of less than the market basket will not account for the cost of goods and services required to deliver LTCH services and will result in rates below the cost of care. Our LTCH members serve a unique population of patients—those that are too medically complex to be discharged to home, skilled nursing facility, or even acute rehabilitation settings, and yet not acute enough to warrant continued stay in the intensive care unit setting. LTCHs, therefore, provide a viable means of addressing patient flow challenges in the acute care setting, while simultaneously meeting the complex medical needs of this special group of patients.

Budget-Neutral Re-Weighting of the LTCH DRGs

The LTCH DRGs contain the only exception under Medicare in that they may be re-weighted in a non-budget-neutral manner—a method that CMS utilized in RY 2007 to reduce Medicare payments to LTCHs. LTCH DRG re-weighting coincides with the annual re-weighting of the DRGs for general acute care hospitals, and takes effect each October 1. It captures changes in the relative cost of treating patients in each of the 538 LTCH DRGs, such as treatment patterns, technology, and number of discharges per DRG. In the proposed rule, CMS recommends that the annual re-weighting of the LTCH DRG be conducted on a budget-neutral basis, beginning October 1, 2007. This provision would be included in the FY 2008 proposed and final rules for the inpatient PPS. The agency is proposing this change since analysis of claims from FYs 2003 through 2005 indicates that LTCH coding practices have stabilized, and therefore, the most recent case-mix increases primarily are due to higher patient severity rather than coding behavior, which had been identified as the primary cause during prior years.

HAP supports CMS' proposal to establish a budget neutrality requirement for the re-weighting of the LTC-DRGs and urges CMS to proceed with this proposal. We appreciate the fact that the LTCH payment system would be in alignment with others under Medicare.

alternative described below; as a result, Medicare payments to LTCHs were reduced by an estimated $156 million. Currently, short-stay outlier cases are paid the lesser of four payment alternatives:

- 100 percent of patient costs.
- 120 percent of the per diem of the LTCH DRG payment.
- Full LTCH DRG payment.
- A blend of the general hospital inpatient PPS per diem and 120 percent of the LTCH PPS per diem. As a patient's length of stay increases, the LTCH DRG portion of the blend increases.

CMS' analysis of FY 2005 MedPAR data shows that 42 percent of LTCH short-stay outlier cases had lengths of stay that were less than or equal to the comparable length of stay (plus one standard deviation) for general acute care hospitals. Further data analysis shows that for ventilator and ventilator/tracheotomy patients, the number of post-intensive care days in the general acute care hospital drop significantly if the patient is discharged to an LTCH—42 percent and 77 percent, respectively. From these analyses, CMS concludes that for cases with a length of stay equal to or less than the comparable general acute hospital stay, a full LTCH payment is inappropriate. The RTI included this proposal in its report to CMS last year.

LTCH patient severity and costs are very different from general acute care patients and validate the need for a separate LTCH payment. Concerns about early discharge from the general acute setting and "double" payment for LTCH cases are already addressed by use of the post-acute care transfer provision that reduces the PPS payment to general acute hospitals that discharge patients to an LTCH. The current short-stay outlier policy significantly reduces payments to LTCHs. Additional changes to further cut LTCH payment are unnecessary.

The current SSO policy became effective as recently as October 1, 2006. Consequently, the most recent changes to the SSO policy will have been in effect for less than one year before the proposed changes would take effect. We find it difficult to accept the fact that CMS is proposing a change to an existing policy whose current impact has not been determined. CMS should wait until data is available to evaluate the effectiveness of its SSO policy changes from last year before making this or any further changes. Therefore, HAP is urging CMS to omit its proposed short-stay outlier policy from the final rule.

Payment for Direct Medical Education

CMS proposes changes relating to Medicare reimbursement for time residents spend working in non-hospital settings, such as physician offices and clinics. Currently, in order for hospitals to receive payments for residents who rotate through non-hospital settings, hospitals must incur "all or substantially all" of the non-hospital site's costs associated with the residents. The proposed rule is intended to reduce the burden on hospitals by allowing the use of proxy data and lowering the cost threshold that must be

incurred in order to demonstrate compliance with the "all or substantially all" requirement.
Specifically, CMS proposes to:

- Allow hospitals to assume that three hours of the physicians' time were spent supervising residents each week or to continue collecting actual data.
- Allow hospitals the choice of using national salary data to estimate teaching physicians' costs by specialty or to continue collecting actual data.
- Create a minimum threshold whereby hospitals must incur at least 90 percent of the sum of residents' salaries, fringe benefits, the portion of the cost of teaching physicians' salaries, and fringe benefits attributable to supervision.

HAP appreciates CMS' effort to reduce the burden currently imposed on hospitals to demonstrate that they have incurred the required costs; however, we fundamentally disagree with CMS' underlying policy. During April 2005, CMS released a set of "Q&As" explaining that hospitals must pay physicians who train residents in non-hospital settings to compensate them for incurred supervisory costs, even when physicians *volunteer* their time. CMS stated that, "where there is a cost to the non-hospital setting for training residents, we believe that the Medicare program is obligated to ensure that the non-hospital settings receive the funding they are entitled to receive from hospitals under the statute." The government does not customarily intervene in private contracts elsewhere in the Medicare program, nor does it establish such detailed policy when overall program spending is not affected. We are concerned that the proposed extensive requirements are going to influence inappropriately the way in which medical education is conducted. We urge CMS to rescind the requirement that hospitals reimburse physicians who wish to volunteer their time.

Three-Hour Proxy

CMS proposes to allow hospitals to use three hours per week as a presumptive standard that a teaching physician spends performing non-patient care direct graduate medical education (DGME) activities at a non-hospital site. To determine the percentage of the average salary associated with the three hours a teaching physician is presumed to spend in non-patient care DGME activities, a hospital would divide three hours by the number of hours the non-hospital site is open each week. The hospital would then multiply this percentage of time spent in non-patient care DGME activities by the national average salary of the teaching physician's specialty to calculate the cost of the teaching physician's DGME time. We question whether this will reduce burden, as it will be difficult for hospitals to implement. Resident rotations are rarely devoted to one non-hospital setting for a month or longer. More often, the rotations consist of partial days or partial weeks over a period of time at a non-hospital setting. Residents may even have three or four clinics that they are regularly visiting each week. For example, continuity clinics, which are required for internal medicine residents, are one half-day a week over three years. If hospitals were to assume three hours of supervisory costs per week per clinic, the estimate would be severely inflated. Thus, hospitals would have no choice but to collect specific information on each clinic, which is unduly burdensome given that

smaller programs often contract with 50 non-hospital sites, and large programs can contract with hundreds.

HAP recommends that CMS allow physicians at non-hospital sites to sign attestation forms estimating their average time spent supervising residents per week.

Salary Proxies

CMS proposes allowing hospitals to use physician compensation survey data as a proxy to determine the teaching physician costs associated with DGME in a program at a non-hospital site, although the hospital could continue to collect the actual data if it chooses. In particular, CMS is requesting comments on whether it should select the American Medical Group Association's annual *Medical Group Compensation and Financial Survey* to determine the cost of teaching physicians' time attributable to DGME or another physician compensation survey.

HAP suggests that CMS consider using reasonable cost equivalents (RCE), which are calculated from CMS' data, available to the public and are a stable source of salary proxies. Another source is the Association of American Medical Colleges' (AAMC's) Faculty Roster Survey salary data, which is collected annually. The AAMC has an excellent response rate and can make its data publicly available. Although the AAMC's data set is external to CMS, it is well-known and stable.

Cost Threshold

CMS proposes revising the current definition of "all or substantially all of the costs" to require hospitals to incur at least 90 percent of the total costs of residents' salaries and fringe benefits (including travel and lodging where applicable), and the portion of the cost of teaching physicians' salaries and benefits attributable to DGME.

CMS should reduce this threshold to 75 percent as there is precedent for such a level in other areas of the program, and there are no implications for Medicare spending.

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

Sincerely,

Paula A. Bussard

PAULA A. BUSSARD
Senior Vice President
Policy & Regulatory Services

/md

Submitter : Mr. Robert Notarianni **Date:** 03/26/2007

Organization : Long Term Hospital of Anniston

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1529-P-112-Attach-1.PDF

#112

Long Term Hospital of Anniston

March 25, 2007

BY ELECTRONIC FILING

Hon. Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1529-P
Mail Stop C4-26-5
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: ***Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes; Proposed Rule, 72 Fed. Reg. 4776 (February 1, 2007)***

Dear Ms. Norwalk:

This letter presents comments and recommendations of Long Term Hospital of Anniston (LTHA) to certain aspects of the proposed annual payment rate updates and policy changes under the prospective payment system for long-term acute care hospitals ("LTACH PPS") for rate year ("RY") 2008, which were published by the Centers for Medicare & Medicaid Services ("CMS") on February 1, 2007.

LTHA is a not-for-profit 34 bed long term acute care hospital located in Anniston, Alabama, and is part of the not-for-profit health care system Noland Health Services (NHS) which is headquartered in Birmingham, Alabama. We employ more than 100 people and in our most recently completed fiscal year we admitted 370 patients to our facility.

LTHA is located within Northeast Alabama Regional Medical Center (NEARMC) which is a not-for-profit regional medical center serving a large portion of eastern and northeastern Alabama. NEARMC is the dominant Medicare provider in its service area.

LTHA is gravely concerned that the future of our not-for-profit mission will be jeopardized by CMS' continued focus on arbitrary and capricious reimbursement changes, rather than addressing a rationalization of the need for this very special level of care for the small segment of Medicare beneficiaries who require extended acute care.

LTHA opposes the arbitrary and inappropriate reductions in long-term care hospital ("LTACH") payments that will result if these proposed changes to the LTACH PPS are implemented. LTHA has reviewed the proposed rule and agrees with ALTHA that it suffers from a number of recurring problems. First, as with other recent rulemakings affecting LTACHs, CMS continues to rely upon materially flawed and incomplete data in developing their proposed changes to LTACH payments for RY 2008. Second, LTHA does not believe that CMS has seriously considered the legal and equitable issues which

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for LTACH certification (*e.g.*, 21 days, 23 days). LTHA strongly encourages CMS not to make further changes in the SSO policy based upon the data provided herein and because MedPAR data is not available yet to evaluate whether the SSO policy changes put into effect last year are achieving the desired policy goals. CMS has produced no study or analysis in the proposed rule showing that inappropriate admissions constitute a material portion of SSO cases. To the contrary, the opposite is true: SSO cases are, in fact, appropriate for admission to LTACH's for a number of reasons, including the fact that even shorter stay LTACH's patients are more severely ill than comparable STACH patients; difficulty in screening SSOs from admission to LTACH's based upon clinical criteria at the time of discharge from the referring hospital; the inability of clinicians to predict when LTACH patients will expire; and the inherent averaging of patient lengths of stay that is the foundation of the current LTACH certification criteria and PPS. If the patient meets InterQual admission criteria, and can be reasonable expected to stay for an extended period of time, and a physician admits the patient, the LTCH should not be so severely financially penalized that negative operating margins are created. 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. It would seem that CMS would be aware that the rate of payment for these cases will be insufficient to cover LTHA's and other LTCH's reasonable and necessary costs in providing care to this segment of LTACH patients.

The proposed policies violate the statutory requirement that CMS reimburse LTACH's on a per discharge basis that reflects the reasonable and necessary cost of providing services in a hospital having an *average* length of stay of greater than 25 days. The proposed policies will continue to erode the LTACH PPS by reimbursing LTACH's for fewer and fewer medically complex patients at the LTACH PPS rates. The LTACH PPS must adequately reimburse LTACH's for the costs they incur in caring for Medicare beneficiaries. The cumulative effect of the proposed changes to the LTACH PPS will be to bring LTACH reimbursement below the cost of care. This level of reimbursement is unsustainable and will inevitably result in a decrease in access to LTACH services in spite of the increasing number of Medicare beneficiaries and the overall aging of the country's population. The Congress, the LTACH industry, MedPAC, and RTI International all agree that LTACH's serve an important role in caring for medically complex patients who need long-term hospital stays. CMS should develop policies that reflect this consensus. We encourage CMS to work with the Congress to develop meaningful facility and patient certification criteria for LTACH's, as proposed in H.R. 562 and S. 338.

LYHA objects to CMS's proposal to provide less than the full market basket update of 3.2% for RY 2008. An increase of less than the market basket will not account for the cost of goods and services required to deliver LTACH services and will result in rates below the cost of care. The full market basket update is an accurate reflection of items and services purchased to treat Medicare beneficiaries and is necessary to account for the rising cost of inputs. The federal rate must be updated in accordance with the market basket to keep LTACH payment rates in step with the higher cost of price inputs.

In summary, LTHA urges CMS to carefully consider the comments and data provided in this letter and to reexamine the policies advanced in the proposed rule. The types of patients admitted to LTACH's, the care provided during an LTACH stay, and the relationships that LTACH's have with STACH's show that Medicare is not paying twice for a single episode of care. LTACHs serve a distinct and important purpose in the health care continuum. LTHA is vital to the mission of Noland Health Services, of meeting unmet healthcare needs for an underserved population in Alabama. CMS's payment policies should reflect this in a manner that fairly compensates LTACH's for the care they provide to thousands of Medicare beneficiaries in Alabama and across the nation.

Sincerely,

Robert G. Notarianni,
Administrator

Submitter : Ms. Rose Popovich **Date:** 03/26/2007

Organization : Community Health Network

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

Please see attachment.

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

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

Submitter : Darby Brockette **Date:** 03/26/2007

Organization : Ernest Health, Inc.

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1529-P-114-Attach-1.DOC

#114

March 26, 2007

Via Electronic Submission

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
Attn: CMS-1529-P
Room 445-G, Hubert Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-1529-P – Comments Regarding Proposed Changes to the Long-Term Acute Care Hospital Prospective Payment Systems and Rate Year 2008 Rates

Dear Administrator Norwalk:

On behalf of Ernest Health, Inc. ("Ernest" or "EHI"), I am writing to comment on the "Prospective Payment System for Long-Term Care Hospitals for Rate Year 2008; Proposed Annual Payment Rate Updates, and Policy Changes" ("Proposed Rule").[1] Given the significant impact of the proposed changes on long-term acute care hospitals ("LTCH"), we appreciate your consideration of our concerns and requests, as set forth below.

I. Background

Ernest is a New Mexico-based company specializing in the development and operation of post-acute care LTCHs and rehabilitation hospitals dedicated to the recovery of patients with chronic or medically complex conditions, as well as patients with functional deficits as a result of injury or illness. EHI was founded on the belief that there is a need for LTCH and rehabilitation services in rural and underserved communities, and that such services can be delivered in a cost-effective manner. Consistent with this belief, EHI currently operates community-based LTCHs in Post Falls, Idaho; Provo, Utah; Laredo, Texas; and Mesquite, Texas. In addition, EHI will be opening LTCHs within the next several months in Las Cruces, New Mexico; Billings, Montana; Loveland, Colorado; and Boise, Idaho. While some of these communities are considered "rural"

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[1] 72 Fed. Reg. 4776 (February 1, 2007).

by CMS, others are located in smaller Metropolitan Statistical Areas ("MSAs") served by one or two primary acute care hospitals.[2]

Ernest believes that the post-acute care needs of patients in these communities have been neglected by other LTCH providers. To overcome this limitation, Ernest develops LTCHs that are "right-sized" to meet the needs of the community, which occasionally calls for an LTCH as small as 15 beds. To make it economically feasible to operate relatively small facilities, Ernest often explores the possibility of co-locating the LTCH with an inpatient rehabilitation facility, so that the overhead costs attributable to the facility may be spread over two separate health care providers. Note, however, that EHI has not co-located an LTCH within an acute care hospital.

II. Proposed Expansion of Special Payment Provisions of 42 C.F.R. § 412.534 to Freestanding LTCHs

CMS is proposing a dramatic expansion of the payment limitations imposed by 42 C.F.R. § 412.534 (hereinafter, the "25 Percent Rule") to all LTCHs, regardless of their proximity to the referring hospital. Currently, the 25 Percent Rule applies only to co-located LTCHs. Ernest opposes this proposed expansion of the 25 Percent Rule to freestanding LTCHs and urges CMS to reconsider this proposal.

Ernest is well aware of CMS' "decade-old concern" over inappropriate patient shifting between acute care hospitals and co-located LTCHs. To address this concern, CMS adopted the 25 Percent Rule several years ago. Under that Rule, when an LTCH is co-located with another hospital, no more that 25 percent of the LTCH's admissions from the co-located hospital will be paid at the full LTCH prospective payment rate. To the extent the LTCH receives more than 25 percent of its admissions from the co-located hospital, the LTCH payments for those patients exceeding the 25 percent threshold would be adjusted to the lesser of what is paid under the LTCH prospective payment system or an amount equivalent to what Medicare would pay under the inpatient prospective payment system.

Following the adoption of the 25 Percent Rule, CMS observed a shift in the growth patterns of LTCHs from co-located facilities to freestanding facilities that would not be affected by the 25 Percent Rule. CMS also reports the existence of certain "cross-referral" arrangements

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[2] None of the markets served by EHI are the areas where MedPAC has observed most of the growth in LTCH providers (see, MedPAC Report to Congress, June 2004, Defining Long-Term Care Hospitals, p. 124).

involving co-located LTCHs and acute care hospitals, implemented presumably as a means of avoiding the 25 Percent Rule. Thus, CMS remains concerned about inappropriate referral arrangements between acute care hospitals and both co-located and freestanding LTCHs, even following the implementation of the 25 Percent Rule. CMS is particularly troubled by the prospect that LTCHs may be admitting patients discharged from acute care hospitals prior to the delivery of a full episode of care to the patient. In these instances, CMS is concerned that it is making two payments for "what is essentially one episode of care" — one payment to the acute care hospital and one payment to the LTCH.[3]

Ernest shares CMS' concern over inappropriate patient shifting between acute care hospitals and LTCHs, and appreciates the agency's desire to implement a prophylactic rule to prevent any type of gaming that may be taking place between LTCHs and acute care hospitals. Expansion of the 25 Percent Rule to freestanding LTCHs, however, is not a solution to the problem. First, we believe the assumptions underlying the 25 Percent Rule are flawed and the application of a numeric threshold of referrals to the LTCH from an acute care hospital says nothing about the appropriateness of either a patient's discharge from the acute care hospital or a patient's admission to the LTCH. In this regard, Ernest disagrees with the agency's suggestion that an LTCH which receives more than 25 percent of its patients from an acute care hospital (or whatever the applicable referral limitation might be) is (1) functioning as a step-down unit of that hospital, (2) admitting patients who are not appropriate for an LTCH level of care, or (3) providing care that the acute care hospital should have furnished to the patient while admitted to the acute care hospital.

Second, the proposed expansion of the 25 Percent Rule to freestanding LTCHs would apply unfairly to freestanding LTCHs located in rural communities or MSAs served by one or two dominant hospitals, which are precisely the types of communities served by EHI. As noted above, Ernest focuses on the LTCH needs of communities previously not served by any LTCH providers. In most instances, these communities are served by one or two primary acute care hospitals. Of course, individuals who require hospital care in these communities are admitted to these hospitals and, by necessity, an overwhelming majority of patients in these areas who need LTCH services following their acute care hospitalization will be discharged from these MSA dominant hospitals and referred to an LTCH.

CMS attempts to accommodate LTCHs located in rural areas or in MSAs served by one or more "MSA dominant hospitals" (i.e., hospitals that generate more than 25 percent of the

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[3] See 72 Fed. Reg. at 4812 (Feb. 1, 2007).

Medicare discharges in the MSA) by increasing the percentage of referrals the LTCH may receive from the hospital before the payment reductions are imposed, but only up to 50 percent. Thus, even if an MSA dominant hospital is responsible for 65 percent of the Medicare discharges in the MSA, its referrals to the LTCH will be capped at 50 percent. Payment to the LTCH for any patients referred from that hospital to the LTCH in excess of the 50 percent cap would be adjusted to the lesser of what is paid under the LTCH prospective payment system or an amount equivalent to what Medicare would pay under the inpatient prospective payment system. CMS also excludes discharges that have qualified for outlier payments from the determination of percentage of referrals received by an LTCH from a particular hospital. That is, Medicare discharges that have already qualified for outlier payments at the acute care hospital would not be included in the count of Medicare discharges admitted to the LTCH from the acute care hospital. While these measures may be helpful for some LTCH providers, they do not sufficiently address the situation of Ernest and other LTCH providers that serve rural and/or smaller urban areas, as illustrated by the examples discussed below.

Ernest operates the Northern Idaho Advanced Care Hospital ("NIACH"), a 40-bed LTCH located in the CBSA of Coeur d'Alene, Idaho. NIACH serves the communities of Northern Idaho and Eastern Washington and is the only LTCH within a 300-mile radius. There is only one "MSA dominant hospital" in the area — Kootenai Medical Center — which is responsible for over 90 percent of the Medicare discharges in the MSA. While NIACH does not receive 90 percent of its referrals from Kootenai Medical Center, it receives well over 50 percent of its referrals from this tertiary care center.

Ernest is about to open the Advanced Care Hospital of Southern New Mexico, a 20-bed LTCH in Las Cruces, New Mexico. The Las Cruces community is served by two dominant acute care hospitals, both accounting for approximately 50 percent of the Medicare discharges in the MSA. Currently, medically complex patients in need of LTCH services are transported roughly 50 miles to another state to receive LTCH services. Alternatively, some patients are admitted to skilled nursing facilities that are not equipped or staffed to care for these severely ill, medically complex patients.[4] In short, the development of an appropriately-sized LTCH in this community will fill a critical and previously unmet need for post-acute care services. And while it may appear that this LTCH will not be affected by the 25 Percent Rule, because the referral

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[4] As MedPAC found, treating LTCH patients in the inappropriate setting (i.e., a skilled nursing facility) often costs the Medicare program more money for a patient's total episode of care, as compared to the cost of the care had the patient been admitted to an LTCH. See MedPAC Report to Congress, June 2004, Defining Long-Term Care Hospitals, pp. 126 and 127.

thresholds for these MSA dominant hospitals would be increased to 50 percent, that is not the case. Often times, the number of referrals to an LTCH from an acute care hospital will not mirror the percentage of Medicare discharges from that acute care hospital. In many instances, if there are two MSA dominant hospitals in a community, one hospital will generate a higher number of LTCH discharges due to the scope of services it provides to the community.

If these Ernest LTCHs receive referrals from the MSA dominant hospitals in excess of the applicable referral thresholds, CMS assumes that the LTCHs are operating as step-down units of the acute care hospitals. CMS also assumes that patients admitted to the LTCHs in excess of the 50 percent threshold were inappropriately discharged from the acute care hospital and/or inappropriately admitted to the LTCH. This simply is not the case. EHI's LTCHs are meeting a community need for LTCH services, a need that had long gone unmet, and that is the reason a majority of patients discharged from these MSA dominant hospitals in need of LTCH services will be referred to the Ernest LTCHs.

Excluding from the percentage of referrals received by an LTCH those Medicare discharges that have qualified for outlier payments at the acute care hospital is not a viable solution. First, the LTCH has no control over when a patient is discharged from the acute care hospital, which is a decision left up to the judgment of each patient's attending physician and based on generally accepted discharge criteria. Second, whether a particular patient qualifies for outlier payments at the acute care hospital bears no relationship to whether that patient is appropriate for LTCH care. Third, this approach places the burden on the LTCH to determine whether a particular patient has qualified for outlier payments at the acute care hospital, and then imposes a substantial payment reduction on the LTCH if the patient did not so qualify.[5] Finally, if CMS is concerned that acute care hospitals are discharging patients prematurely (i.e., prior to completing an episode of care), then it should address this issue directly with acute care hospitals and not indirectly through a punitive payment reduction imposed upon LTCHs.

Indeed, CMS's proposal will not result in any net savings to the Medicare program, but will 1) negatively affect the provision of LTCH services to patients in rural communities or communities with one or two MSA dominant hospitals, and 2) ultimately harm patients who need LTCH services. That is, when the number of referrals from an acute care hospital to an LTCH reaches the applicable threshold, one of five potential situations will unfold. First, the

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[5] Note also that the LTCH will not have access to this information at the time the patient presents for admission and must rely on the acute care hospital to inform the LTCH of whether a patient qualifies for outlier payments.

patient will be referred to the LTCH prior to qualifying for outlier payments, and the LTCH's payment for services furnished to that patient will be drastically reduced. Second, the patient will be referred to a skilled nursing facility and not receive the LTCH care he/she requires. Third, the patient will remain in the acute care hospital until he/she qualifies for outlier payments and then referred to the LTCH. Fourth, the patient will be referred to an LTCH located outside the community or state, at a tremendous hardship to the patient and his/her family. Fifth, the patient's condition will improve while remaining in the acute care hospital (awaiting to qualify for outlier payments) such that LTCH services are no longer necessary.

The unfortunate reality is that patients who find themselves in this situation will either be transferred to an LTCH outside the community or state to receive the needed LTCH care, or be transferred to a local skilled nursing facility and forego the LTCH care they require. We believe it is unlikely that the LTCH would accept an admission of these patients, knowing that it will receive a drastically reduced payment for the care provided. We also doubt that the acute care hospital will continue to provide care to these patients until they qualify for outlier payments. Nor is it likely that the condition of these patients will improve while remaining in the acute care hospital to the extent that he/she no longer qualifies for LTCH care. Thus, the most likely result of CMS' proposal is that these patients will be either referred to an LTCH outside their community or transferred to a skilled nursing facility. In neither case will these patients receiving the LTCH care they require in the LTCH serving their community.

Moreover, in three of these five scenarios, the Medicare program will make at least two payments (and possibly three) in relation to the hospital care furnished to the patient — one or two payments to the acute care hospital (depending on whether the patient qualifies for outlier payments) and one payment to the LTCH. Moreover, MedPAC found that treating patients in need of LTCH care in the inappropriate setting, such as skilled nursing facilities, often costs the Medicare program more money for a patient's total episode of care, as compared to the cost of the care had the patient been admitted to an LTCH in the first place.

In short, CMS' attempt to address its concerns regarding inappropriate admissions to LTCHs through the expansion of the 25 Percent Rule does not accomplish the agency's objectives, will not result in any material savings to the Medicare program, and disproportionately affects those LTCH providers, like Ernest, that establish facilities in rural or smaller urban communities with an unmet need for LTCH services. What the proposal will accomplish, however, is to ensure that those underserved communities with a demonstrated need for LTCH services will remain underserved, and Medicare beneficiaries residing in those communities who need LTCH services will either go without the service or be required to travel significant distances to the closest LTCH to obtain the service. Indeed, application of the 25 Percent Rule, as currently proposed, to LTCHs such as the Advanced Care Hospital of Southern

New Mexico and the Northern Idaho Advanced Care Hospital, would be tantamount to denying the residents of these communities, and all similarly situated communities, the benefits of a local LTCH provider.

III. Alternatives to CMS' Proposed Expansion of the 25 Percent Rule

As noted above, we believe that there are unintended, adverse consequences of expanding the 25 Percent Rule to freestanding LTCHs, especially for those LTCHs located in rural areas or areas served by one or two MSA dominant hospitals. For those reasons, we offer the following alternative approaches for CMS to consider.

A. Do Not Finalize the Proposal and Implement MedPAC Recommendations

Ernest urges CMS not to finalize this proposal. We believe the 25 Percent Rule serves as a poor proxy for measuring the clinical appropriateness of LTCH admissions. Instead of expanding the 25 Percent Rule, CMS should continue its efforts to develop patient-centered and facility-centered criteria that would delineate the types of patients who are appropriately treated in LTCHs and more accurately define these facilities. CMS' efforts in this area are consistent with the recommendations to Congress made by MedPAC in its 2004 Report to Congress addressing LTCHs. Specifically, MedPAC recommended the development of facility and patient focused certification criteria in order to control any unnecessary growth of LTCHs and to ensure that patients treated in LTCHs are those for whom an LTCH level of care is most appropriate. Ernest supports this approach and would be delighted to work with CMS to develop such criteria.

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

For the same reasons MedPAC found the current LTCH 25-day length of stay criterion ineffective in preventing the inappropriate admission of patients to LTCHs, the 25 Percent Rule is equally ineffective at predicting the appropriateness of admissions to LTCHs and discharges from acute care hospitals. This is especially the case for LTCHs located in communities served

IV. Conclusion

As proposed, we oppose any expansion of the 25 Percent Rule to freestanding LTCHs, as it is an ineffective and arbitrary predictor of the appropriateness of LTCH admissions. In addition, compliance with the 25 Percent Rule will be exceedingly difficult for LTCHs serving communities in which there are only one or two MSA dominant hospitals and effectively stifle the growth of LTCHs in underserved areas. Consequently, residents of these communities in need of LTCH services would be required to travel outside the community to receive the necessary services, or receive care in a setting that is not designed or capable of treating severely ill medically complex patients. Both scenarios are unacceptable. Instead of expanding the 25 Percent Rule to freestanding LTCHs, CMS should (1) modify its existing proposal and invest further efforts to refine metrics designed to specially address the paramount concern of assuring appropriate inpatient discharges that will result in a more effective proposal in future rulemaking cycles; (2) develop the types of clinically-based certification criteria recommended by MedPAC, which focus on patient characteristics and the level of care that should be available at every LTCH; or (3) consider implementation of the alternative approach discussed above, which serves as a better proxy for assessing the appropriateness of LTCH admissions than CMS' current proposal.

* * * *

In closing, on behalf of Ernest, I would like to thank CMS for providing us this opportunity to comment on the Proposed Rule. Please feel free to contact me at (505) 856-5300 if you have any questions or if Ernest can provide any assistance as you consider these issues.

Respectfully submitted,

/s/

Darby Brockette, Chief Executive Officer
Ernest Health, Inc.

Submitter : **Mr. Stephen Harwell** **Date: 03/26/2007**

Organization : **Healthcare Association of New York State**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Attached please find HANYS' comments.

CMS-1529-P-115-Attach-1.DOC

#115

Healthcare Association
of New York State

March 26, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: (CMS–1529–P) Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes; Proposed Rule, (Vo. 72, No. 21), February 1, 2007.

Dear Ms. Norwalk:

The Healthcare Association of New York State (HANYS), on behalf of our more than 550 hospitals, nursing homes, home health agencies, and other health care providers, welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule for Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) policy changes.

CMS has proposed changes related to the amount of time medical residents can spend in non-hospital settings. Currently, under certain circumstances, hospitals are allowed to count the time residents spend training in non-hospital settings if the hospital incurs "all or substantially all" of the costs for training those residents in the non-hospital setting.

HANYS appreciates CMS' efforts to reduce hospitals' burden of demonstrating that the required costs have been incurred. However, we disagree with CMS' current policy that requires hospitals to incur costs for physicians who volunteer their time at non-hospital sites in order to count the resident's time for purposes of IME and DGME payments. The government does not customarily intervene in private contracts elsewhere in the Medicare program, nor does it establish such detailed policy when overall program spending is not affected. HANYS has strong concerns that the proposed extensive requirements would inappropriately influence the way medical education is conducted. **HANYS supports the American Hospital Association (AHA) in urging CMS to rescind the requirement that hospitals reimburse physicians who wish to volunteer their time.**

Cost Threshold
CMS is proposing to reduce from 100% to 90% the cost threshold that hospitals are required to incur for residents' salaries, fringe benefits, the portion of the costs of teaching physicians' salaries, and fringe benefits attributable to supervision in a non-hospital setting. **HANYS agrees that CMS should reduce the cost threshold; however, a more appropriate level would be 75%.**

There is precedent for such a level to be set at 75% in other areas of the program and there are no implications for Medicare spending.

Three-Hour Proxy
CMS is proposing to set a three-hour per week proxy as a presumptive standard for the amount of time a physician spends performing non-patient care DGME activities at a non-hospital site. Resident rotations are seldom devoted to only one non-hospital site; therefore, residents who visit more than one clinic each week could severely increase the estimated costs per clinic based on CMS' proposed calculation. **HANYS joins AHA in recommending that CMS provide an alternative that would allow physicians at non-hospital sites to sign attestation forms estimating their average time spent supervising residents per week.**

Physician Salary Proxy
CMS is proposing to use national average physician salary information as a proxy to aid hospitals in determining the portion of the teaching physicians' cost attributable to DGME in the non-hospital setting, although hospitals do have the option to continue collecting actual data. HANYS agrees with CMS that a physician salary proxy is necessary if actual physician salary data are not obtainable, since providers are required to incur "all or substantially all" of the costs for training residents in a non-hospital setting. **However, HANYS joins AHA in suggesting that CMS consider using reasonable cost equivalents (RCEs), which are calculated from CMS' data, available to the public, and are a stable source of salary proxies.**

If CMS decides against using RCEs, we recommend using the Association of American Medical Colleges' (AAMC) Faculty Roster Survey salary data, which is collected annually. AAMC has an excellent response rate and can make its data available to the public.

Thank you for the opportunity to comment on the proposed rule for DGME and IME policy changes. Although HANYS supports CMS' proposed rule conceptually, we believe modifications are necessary to ensure that hospitals endure less burden and more reliable proxies are used.

Sincerely,

Stephen Harwell
Director, Economic Analyses

SH:djo

#116

AMERICAN COLLEGE OF OSTEOPATHIC INTERNISTS

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www.acoi.org

March 26, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY: 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes, 72 Fed. Reg. 4776 et seq. (February 1, 2007)(CMS-129-P)

Payment for Direct Graduate Medical Education

Dear Administrator Norwalk:

The American College of Osteopathic Internists appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' Proposed Rule as it relates to Hospital Direct and Indirect Graduate Medical Education Policy Changes.

The American College of Osteopathic Internists (ACOI), which represents the nation's osteopathic internists and medical subspecialists, is dedicated to the advancement of osteopathic internal medicine through excellence in education, advocacy, research and the opportunity for service. Osteopathic internal medicine training programs are designed to provide residents with comprehensive structured cognitive and procedural clinical education in both inpatient and outpatient settings that will enable them to become competent, proficient and professional osteopathic internists and subspecialists.

Training at nonhospital ambulatory sites is an integral part of our residency programs. Although we have some concern with a few of the proxies set forth, the proposed rule published in the *Federal Register* on February 1, 2007 takes substantive steps towards redefining "all or substantially all" of the costs associated with resident training at nonhospital sites. Therefore, the ACOI recommends the adoption of the proposed rule with amendment.

90 Percent Rule

As noted in the proposed rule, federal statute has set a priority to facilitate training in nonhospital settings. Efforts to accomplish this goal have been hampered by a cumbersome and confusing process to calculate full-time equivalent (FTE) residents for purposes of direct graduate medical education payments in relation to training at nonhospital sites. To this end, the ACOI appreciates and applauds CMS' efforts to redefine and clarify the determination of "all or

substantially all" costs for the purposes of GME training at nonhospital sites. Further, we welcome adoption of the "90 percent rule."
The current interpretation and application of "all or substantially all" creates a system marked by a lack of clarity and makes compliance excessively burdensome. The proposed 90 percent rule takes an important step in clarifying and streamlining the process to calculate "all or substantially all" of the costs associated with resident training outside the hospital setting. While discussed peripherally in the proposed rule in relation to "all or substantially all" of the costs associated with resident training in a nonhospital setting, we do encourage CMS to reexamine the utilization and benefit of volunteer faculty in the future.

Three Hour per Week Presumption
The proposed rule provides three hours per week as a presumptive standard number of hours that a teaching physician spends in nonpatient care GME activities at a particular nonhospital site. Unfortunately, this presumption does not reflect the realities of medical residencies. This results in a fundamental flaw in the calculation to determine whether the proposed 90 percent threshold is reached by a training program.

Specifically, the three hour per week presumption assumes that a resident spends a full week at a nonhospital site. This is often not the case. For example, under the ACOI's *Basic Standards for Residency Training in Internal Medicine*, a first-year resident is required to participate in a ½ day per week of continuity ambulatory experience for a minimum of 44 weeks. This is standard residency training policy and not unique to osteopathic internal medicine. To this end, the three hour presumption would result in a calculation suggesting that a teaching physician spends almost as much time in nonpatient care GME as the resident spends at the training site in total. As a result, under the proposed rule, the three hour presumption creates an inappropriate weight for the time provided by training physicians at the nonhospital sites where a resident trains.

We understand that under the proposed rule an institution can utilize actual data instead of a proxy in calculating whether they reached the 90 percent threshold in paying "all or substantially all" of the costs associated with resident training at a nonhospital site. We believe, however, the intent of the proxies is to reflect the general GME environment. To this end, we strongly encourage CMS to revisit the three hour per week presumption. Further, we believe that the three hour presumption is high and should be altered to better reflect actual training experiences. Due to the central importance of calculating the cost of the training physician's time, the three hour presumption must be reviewed and adjusted downward prior to adoption of the final rule. Alternatively, CMS should consider a mechanism to prorate the three hour presumption so that it reflects the regular occurrence of residents spending less than a full week at a nonhospital setting, which may result in even less nonpatient care GME activities by the teaching physician.

Implementation Date
The ACOI believes the current GME formula for calculating FTE residents for purposes of direct GME payments is overly burdensome. As a result, the proposed rule, which address some of the current system's problems, should become effective immediately. That is, the proposed rule, with amendment, should take effect for portions of cost reporting periods occurring on or after July 1, 2007. While there remain some concerns with regard to the application of the rule to internal medicine training programs, the rule is a great improvement upon the rules now in place.

We appreciate that immediate implementation of the proposed rule may be difficult and will present some challenges. We are, however, confident that CMS can overcome any barriers that may exist to create a more streamlined and efficient methodology to calculate "all or substantially all" of the costs associated with resident training at nonhospital sites. Adoption of the amended rule in a timely fashion will enhance graduate medical education and as such deserves the prompt attention of CMS.

The ACOI appreciates the opportunity to provide these comments. We look forward to working with CMS in the future on these and other issues of importance impacting the nation's health care delivery system.

Sincerely,

Joanna R. Pease, DO, FACOI
President

Submitter : Dr. Keith Holten **Date:** 03/26/2007

Organization : Clinton Memorial Hospital

Category : Hospital

Issue Areas/Comments

Background

Background

Residency programs in primary care depend on office-based rotations to train residents. This is especailly true in Family Medicine residencies. Having an adequate number of office based preceptors is critical.

GENERAL

GENERAL

Please do not approve these rules.

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

The proposed rules would ereate a tremendus burden on residency programs to administer these office based rotations. It would be nearly impossible to administer in our program. It would challenge us to find solutions for training within our hospital to improve funding. No options exist which would replicate our current experience.

Submitter : **Mrs. Janice Myers** **Date: 03/26/2007**

Organization : **Spectrum Health Hospital**

Category : **Hospital**

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

March 26, 2007

Administrator
Centers for Medicare & Medicaid Services

Attention: CMS-1529 P Proposed rule on changes to the policies for receiving Medicare DGME/IME payments for residents training at nonhospital sites

Dear Administrator:

Spectrum Health Hospitals welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule Proposed rule on changes to the policies for receiving Medicare DGME/IME payments for residents training at nonhospital sites. 72 Fed. Reg. 4776 (Feburary 1, 2007).

We train approximately 300 residents at 285 different non-hospital sites for about 1475 rotations a year. We have non-hospital rotations that are a month block, where the resident is off-site for most of the rotation. We have split rotations where the resident spends time with an attending both at the hospital and at the private physician s office. These are usually for a month to a six week block. The time spent in the physicians office varies from 20% to 75% of the rotation with the remainder of the rotation taking place at the hospital. We also have rotations where the time a residents spends at the nonhospital site varies anywhere from a couple hours a month, to two half days a month, to 1 day a week for a month, with many variations in between. These brief hours of non-hospital time are usually incurred by orthopedic and surgical residents spending time with several different surgeons and could encompass several different physician practices.

While the 3 hours a week didactic time seem high even for our month long rotations, it would at least be workable in your formula to calculate the 90% threshold for these rotations. But as our month long rotations make up only a small percentage of our non-hospitals rotations this formula only works well for a few of our rotations.

It could be a workable solution for our split rotations, if all three components of the formula are prorated equally, the resident salary and benefits, the 3 hours a week didactic time, and the teaching physician s salary. The formula would need to be prorated to the time spent offsite during the split rotations. The same would apply to our one hour/one day surgery rotations, the formula would need to prorate all three components.

Many specialists and surgeons have set office days or half days where they see patients and the rest of the time is spent at the hospital. It does not seem reasonable that if a resident is spending one morning a week or a month (3 to 4 hours) working with these physicians during their office hours that the teaching physician is going to be able to spend 3 hours of that time in didactic training. Most of the didactic training during these rotations takes place at the hospital.

It would also be difficult to include the total compensation amount the hospital will incur to meet the 90% threshold, and whether this amount includes teaching physician costs on the training agreements. The salary and fringe benefits paid to the residents change as the resident progresses through the residency program. The PG2 resident is paid more than the PG1 resident. Also at issue is the varying length of the offsite rotations, from a half day to six weeks. One teaching physician could be training several residents at different levels, for different lengths of offsite time. The amount of time spent in the physician s private office is not always known until the rotation is taking place, making it difficult to put the compensation into a training agreement signed before the start of the rotation.

Spectrum Health Hospitals

Submitter : Dr. Michael Baxter **Date:** 03/26/2007

Organization : Reading Hospital and Medical Center

Category : Physician

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

As the director of an 18 resident community based Family Medicine residency program which has trained over 150 Family Physicians for PA and other regions, I am extremely concerned regarding the impact of the proposed payment change for community training in such residencies. Family Medicine is not only the cornerstone of health care in many of our communities, it is also the most cost-effective and efficient method of health care delivery in this country due to the broad training of Family Physicians. This wide breadth of training requires a wide range of practice settings particularly in community ambulatory practices where most health care takes place. Changing the funding formula would severely impact the financial stability of these primary care training programs which train disproportionately in non hospital sites. Weakening of such programs would further impede our national priorities of addressing chronic diseases and meeting the disparate health needs of minority communities often served by Family Medicine residency graduates. Futhermore, such a funding change does not support the time honored medical tradition of physician teaching physician as a professional responsibility.

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

A decline in financial support for Family Medicine residency training
programs will have the very direct impact of many of these programs closing as there is less opportunity to generate additional income from patient care as there is with the lucrative procedural based specialty training programs. The closing of such programs would not only negatively impact the health care of local communities (often indigent populations) where family medicine residency health centers are located, but also impact the accessibility of quality health care for the broad segment of our population that relies on Family Physicians of the present and future to provide care for themselves and their families.

Submitter : **Mr. Lou Little** **Date: 03/26/2007**

Organization : **WellStar Health System**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1529-P-120-Attach-1.DOC

#120

Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1529-P
Mail Stop C4-26-5
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Comments on "Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes; Proposed Rule."

Dear Ms. Norwalk:

WellStar Health System, an integrated healthcare delivery system located in the greater metropolitan Atlanta area, appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed changes to the long-term care hospital proposed payment system (LTC-PPS).

WellStar Health System includes WellStar Windy Hill Hospital, a freestanding LTCH. Windy Hill Hospital was established in 1983 as a general inpatient (short-term care) hospital. In 1996, its Medicare provider status changed to that of an LTCH to meet the growing needs for specialized care organized in this unique setting.

We are concerned that CMS continues to substitute arbitrary payment policy changes for effective rulemaking that implements the recommendations of the Medicare Payment Advisory Council (MedPAC) and CMS' own contractor, the Research Triangle Institute (RTI), with respect to the LTCH provider segment.

In particular, we disagree with the expansion of the so-called 25% Rule imposing penalties to LTCH providers based on referral source and changes to the short-stay outlier (SSO) policy. We also oppose CMS' continued imposition of Inpatient Prospective Payment System (IPPS) rules and payments on providers that Congress has specifically mandated be paid using a separate LTC-PPS system.

Despite a number of concerns with this proposed rule, we do support the move to re-weight LTCH diagnostic related groups (DRG) in a budget-neutral manner.

To assist in streamlining the regulatory process and enhance LTCH industry stability, CMS should have only one annual rulemaking for LTCHs, as is the case with all other Medicare provider types.

Below we expand our comments on a number of our concerns.

Expansion of the "25% Rule" to Freestanding and Grandfathered LTCHs

We oppose the 25% Rule in its entirety - in its existing form for hospital within hospitals (HWH) and satellite hospitals as well as the proposed expansion to include freestanding and grandfathered LTCHs. Our primary concern is that it is arbitrary and designed to limit the access of Medicare beneficiaries to the care that their physician determines is appropriate, necessary and best for their continued treatment and recovery.

As you would expect, LTCH providers who have exceptional clinical outcomes are rewarded by a significant stream of referrals. A logical consequence of CMS' 25% Rule is to penalize these providers and the Medicare beneficiaries they serve. This is especially true in locations that have few referring hospitals. CMS' policy advocates a perverse set of incentives that effectively will drive patients to LTCHs with lesser quality outcomes. When the higher quality LTCH reaches CMS' arbitrary 25% of its referrals from a large referring hospital, they will no longer be able to afford to accept patients, regardless of whether they are clinically appropriate referrals. The result is that these patients will either be referred for care from another LTCH perceived to have lesser quality of care or receive no appropriate LTCH care at all.

We can find no merit in the 25% Rule and urge that CMS not extend it to freestanding and grandfathered hospitals.

We strongly recommend that CMS implement facility and patient criteria as recommended by MedPAC in its June 2004 Report to Congress. In addition, CMS should immediately implement expanded and intensified review of LTCH cases by the Quality Improvement Organizations (QIO) to ensure that Medicare patients meet adequate medical necessity standards.

Short Stay Outlier Payment Policy

CMS has defined SSO patients as those patients whose length of stay is less than 5/6 of the geometric mean length of stay for a particular diagnosis. It is troubling that CMS defines a category of patients that, by statistical definition, will contain a large percentage of LTCH admissions for a given diagnosis. Then CMS points to the incidence of patients falling into that category as evidence that LTCHs are admitting inappropriate cases that should have stayed in the short-term acute hospital.

CMS' current and proposed SSO payment policies will result in significant financial penalties for this large group of cases. This is antithetical to the fundamental precept of PPS design that it be a system of averages. If these policies work as CMS has designed them, they will interfere with the Medicare beneficiary's access to care which is deemed necessary by their physician for their continued care and recovery. .

CMS should not extend its short-stay outlier policy beyond its current form.

Use of IPPS Payment Policy – Impact on Required 25-day Average Length of Stay

We strongly oppose CMS' payment of shorter length of stay patients using schemes involving IPPS payment rates. It is a fundamental underpinning of any PPS that some patients will exhibit shorter lengths of stay, others longer. The resulting averaging of payments is designed to provide an overall payment system that is logical and fair.

CMS is intent, however, on using some hybrid of LTC-PPS and IPPS to pay short stay patients. We urge CMS to eliminate any use of the IPPS in calculating payments for patients admitted to LTCHs. If CMS continues to pay for these Medicare patients' care under a modified IPPS, then these Medicare patients should be excluded from the annual calculation of the LTCH's 25-day ALOS for purposes of qualifying as an LTCH.

Thank you for the opportunity to submit these comments. If you have any questions, please feel free to contact me at (770) 644-1090 or lou.little@wellstar.org.

Sincerely,

Lou Little
VP, Post Acute Services &
Administrator, WellStar Windy Hill Hospital
2540 Windy Hill Road
Marietta, Georgia 30067

Submitter : **Ms. Laura Loeb** **Date: 03/26/2007**

Organization : **American College of Oesteopathic**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Background

Background

Comment on the Proposed Rule published 2/1/2007 regarding long-term care hospitals and graduate medical education (GME) policy changes

GENERAL

GENERAL

See attachment

CMS-1529-P-121-Attach-1.DOC

CMS-1529-P-121-Attach-2.DOC

CMS-1529-P-121-Attach-3.DOC

March 26, 2007

The Honorable Leslie V. Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: **CMS-1529-P**; Medicare Program; Prospective Payment System for Long Term Care Hospitals FY 2008; Proposed Annual Payment Rate Updates and Policy Changes and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes

Dear Administrator Norwalk:

The American College of Osteopathic Surgeons (ACOS) and the American Osteopathic Academy of Orthopedics (AOAO) appreciate the opportunity to comment on the Proposed Rule published in the February 1, 2007 *Federal Register* regarding long-term care hospitals and graduate medical education (GME) policy changes. Our comments will be confined to the proposed GME changes.

In sum, we believe that CMS' proposed new formula for teaching hospitals to use to calculate supervisory teaching costs will assist some residency programs. These actual costs have proven difficult to determine in many situations. However, we continue to be gravely concerned by the unwillingness of CMS to fully acknowledge that teaching physicians often are volunteering their time, and there are no supervisory teaching costs. We urge CMS in the final rule to issue a clear policy statement that the volunteer status of faculty will be determined by the hospital and nonhospital site and that even physicians in group practices who are compensated a predetermined amount not based on patient billings may still be volunteering their teaching services.

Background

Since 1987 a hospital has been able to count the time residents spend in patient care activities in nonhospital sites toward its count for direct graduate medical education (D-GME) funding. However, because a hospital could not count this training time in the nonhospital sites towards indirect medical education (IME) funding, Congress determined that this was a significant

disincentive for residents to spend time in these locations where they could receive very relev and valuable training.

With the passage of the Balanced Budget Act in 1997, Congress corrected this problem and allowed hospitals to recognize this patient care related training time in nonhospital sites for II purposes as well as for D-GME. The goal of Congress was to encourage resident training in these nonhospital locations. Yet, CMS has issued a number of interpretations regarding GMI issues since 1997 that have actually significantly hindered the effectuation of Congressional intent.

For example, in 1999, without any mandate from Congress, CMS issued regulations redefinir "all or substantially all" of the costs that a hospital needs to incur for training in nonhospital settings in order for the hospital to count the resident time for D-GME and IME funding. Previously, CMS had interpreted "all or substantially all" of the costs of a resident training program to entail only the residents' stipend and benefits. Effective in 1999, CMS required tl hospital also to incur the cost of the supervisory teaching time.

In subsequent years, Medicare contractors began denying D-GME and IME funding to hospit because the faculty were volunteers and, therefore, the hospitals paid no supervisory teaching costs for residents training in nonhospital locations in those cases. Most recently, Medicare contractors have been denying D-GME and IME funding for residency training in nonhospita sites even when hospitals have been paying supervisory teaching costs, on the basis that these amounts seemed too low to the Medicare contractor.

Faculty Do Volunteer Their Time

In this proposed rule and the Q&A on this issue released in April 2005, CMS states that it wil assume that physicians in group practices who are paid a predetermined salary not attributable their individual patient care billings could not be volunteering their resident supervision time. CMS believes the predetermined salary must include compensation for teaching.

Unfortunately, Medicare contractors have used this CMS assumption to reach non-sensical conclusions. Contractors have denied D-GME and IME based on insufficient payment for supervisory teaching costs even in situations where the physicians in a group practice were making a set amount in a prior year when there were no residents and are making the same predetermined amount during a year when they are supervising residents. The physicians stat that they were volunteering their teaching time, yet the Medicare contractor refused to acknowledge this, even though the physicians were clearly not receiving any additional compensation when the residents were present.

Volunteer faculty is a strong tradition of osteopathic medicine. The CMS position suggests th it would be rare to have physicians volunteer their time to train residents. That is not the experience in osteopathic medicine. Moreover, we do not believe that training programs shou be penalized for being able to recruit volunteer faculty. It is the programs with volunteer facu that are perhaps most in need of GME funding. Yet these are the programs being denied payment.

CMS itself stated in program transmittal A-98-44, issued on December 1, 1998, that:

> "The determination of what constitutes reasonable compensation [for teaching] is a matter between the hospital and nonhospital site." (attached)

Nevertheless, even when the hospital and nonhospital site agree upon voluntary teaching serv CMS believes there must be an amount attached to this function. CMS appears to be trying t protect the physicians and the residency program, but, in fact, its actions have the exact oppo result.

Proposed New Formula for Calculating Faculty Costs

While CMS apparently has not backed away from its assumptions against volunteer faculty, i proposing a methodology that should make it easier for a hospital to calculate these faculty c if there are indeed faculty costs. We believe that a formula is the right direction for the agenc head. However, this formula must be combined with more stated acceptance on the part of th Agency of the existence of volunteer faculty arrangements.

We would not support this formula being used as a proxy for faculty costs in situations where hospital and nonhospital site have agreed that the faculty are volunteering their time. We do believe that CMS should assume that there must be faculty costs even when the parties declar otherwise. The proxy calculations should not be used in place of the actual intent of the parti We urge CMS to make a clear statement to this effect, *i.e.*, that the intent of the parties is the controlling factor, and that neither CMS nor its contractors will substitute their judgment for t of the parties directing the training program.

However, we are in support of some type of formula being used to calculate faculty costs in those cases where the parties acknowledge that there are costs. Currently, many training programs employ time and effort reporting among the faculty. The faculty by and large have found these reports difficult to complete, and often there is confusion as to how they should characterize their various functions among the categories of patient care, research, teaching, a administrative services. It is also unclear how applicable the standard time and effort reports to the ambulatory office or clinic setting, where the vast majority of time involves patient car

With respect to the proxy for physician compensation used in the proposed formula, it would most appropriate to use median, regionally-adjusted compensation data based on specialty. Compensation varies significantly based on region of the country and specialty and these fact should be taken into account.

Conclusion

We urge CMS in the final rule to clearly acknowledge the existence of volunteer faculty, ever situations of a group practice with predetermined compensation for the physicians that is not based on individual patient care billings. In those situations where there are supervisory teac costs, we support CMS' effort to create a standard formula for the hospital to determine these costs.

We stand ready to work with the agency on this issue. If you or your staff have any questions, please contact Guy Beaumont, Executive Director of ACOS, at 703-684-0416.

Respectfully submitted by,

Alison A. Carey, D.O. FACOS
President, ACOS

Debra K. Spatz, D.O. FAOAO
President, AOAO

Attachment

#121

FY 1999 PPS, TEFRA Hospital, and Other Bill Processing Changes

Program Memorandum (Intermediaries), HCFA Pub. 60A Transmittal No. A-98-44 Dec. 1, 1998

Medicare: Provider Reimbursement

Prospective payment systems—Development of hospital DRG rates—Bill processing.—

A *Final Rule* in the July 31, 1998, *Federal Register* outlined changes for inpatient hospital prospective pay and Tax Equity and Fiscal Responsibility Act of 1982 (PubLNo 97-248) hospital bill processing for fiscal ye Table 1A on FR page 41019 shows a large urban area nonlabor-related amount as $1,313.41, whereas the am be $1,131.38. Additionally, some ICD-9-CM changes, which are contained in the 1999 addendum to volume of the ICD-9-CM, are effective Oct. 1, 1998. Providers should also note that changes have been made in elec record formats, with changes focusing on date fields for millennium compliance and on filler fields for inclus information.

See ¶4200 et seq.

The *Final Rule* was reported at ¶46,378 for electronic subscribers and was sent to all subscribers in pr of Report 1018.

[Text of Transmittal]

SUBJECT: FY 1999 Prospective Payment System (PPS), TEFRA Hospital and Other Bill Processing Chang

This Program Memorandum (PM) outlines changes for inpatient hospital PPS and TEFRA hospitals for FY changes for FY 1999 were published in the *Federal Register* on July 31, 1998. There was an error in Table 1A o of the *Federal Register*. The large urban area nonlabor-related amount shown as $1313.41 is incorrect. It should All items covered in this PM are effective for hospital discharges occurring on or after October 1, 1998 unless c **Inform providers you service of these changes.**

I. *ICD-9-CM Changes*

● ICD-9-CM coding changes are effective October 1, 1998. These are contained in the FY 1999 addendum and 3 of the ICD-9-CM. The coding changes are available in Tables 6a and 6b in the addendum to the final rule for FY 1999. Invalid codes are contained in Table 6c and 6d, and revised diagnosis code titles are in Table 6e o rule.

Grouper 16.0 assigns Diagnostic Related Groups (DRGs) based on the revised ICD-9-CM codes effective w occurring on or after October 1, 1998. Medicare Code Editor (MCE) 15.0 and Outpatient Code Editor (OCE) 1 ICD-9-CM codes to validate coding for discharges and outpatient services effective October 1, 1998.

II. *Furnished Software Changes*

The following software programs were issued for FY 1999:

● **PRICER 99.0** for discharges occurring on or after October 1, 1998. This processes bills with discharge d October 1, 1994.

Section 4415 of Public Law 105-33 amended §1886(b)(1) of the Act to provide for cost reporting periods begi after October 1, 1997, if a hospital's operating costs are greater than the ceiling but less than 110 percent of the ce will be the ceiling. If a hospital's costs are greater than 110 percent of the ceiling, payment will be the ceiling plu the costs in excess of 110 percent of the ceiling. Total payment may not exceed 110 percent of the ceiling.

● New excluded hospitals and units (§413.40(f))

§4416 adds a new §1886(b)(7) of the Act to establish a new statutory payment methodology for new psychiatr units, rehabilitation hospitals and units, and long-term care hospitals. Under the statutory methodology, for a hos within a class of hospitals specified in the statute and which first receives payments on or after October 1, 1997, t payment shall be determined as follows.

For each of the first two cost reporting periods, the amount of payment is the lesser of (1) the operating costs p 110 percent of the national median of target amounts for the same class of hospitals for cost reporting periods en 1996, updated and adjusted for differences in area wage levels. For purposes of computing the target amount for t cost reporting period, the target amount for the preceding cost reporting period is equal to the amount determined methodology above for the preceding period.

The table below lists 110 percent of the wage neutral national median target amounts for each class of exclude cost reporting periods ending during FY 1996, updated by the market basket to FY 1999. For a new provider, the share of the target amount should be multiplied by the appropriate geographic area wage index and added to the n share in order to determine the target amount under the new provider payment methodology.

		Total	Non Labor-Related share	Labor-Related share
(1)	Psychiatric:	$ 6,686	$ 4,214	$ 2,472
(2)	Rehabilitation:	$17,477	$11,219	$ 6,258
(3)	Long-term care:	$22,019	$15,749	$ 6,261

● Capital payments for excluded hospitals and units (§413.40(j))

Section 4412 of Public Law 105-33 amended §1886(g) of the Act to establish a 15 percent reduction on capital certain hospitals and hospital distinct part units excluded from the prospective payment system for portions of cos periods beginning on or after October 1, 1997 through September 30, 2002. The capital reduction applies to psycl hospitals and units, rehabilitation hospitals and units, and long-term care hospitals.

GRADUATE MEDICAL EDUCATION

● General Policy

For portions of cost reporting periods occurring on or after January 1, 1999, the time residents spend in nonpro such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may b determining the number of FTE residents in the calculation of a hospital's resident count for indirect and direct gr education if the following conditions are met:

—the resident is providing patient care in those settings; and

—there is a written agreement between the hospital and the nonhospital site that indicates that the hospital v the costs of the resident's salary and fringe benefits while the resident is training in the nonhospital site and hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. Th

agreement must also indicate the compensation the hospital is providing to the nonhospital site for supervisc teaching activities.

The hospital may count residents training in any nonhospital site including a Federally Qualified Health Center Rural Health Clinic (RHC). If the hospital has a written agreement with an FQHC or RHC that would allow the ho the resident for indirect and direct GME, the written agreement must also:

—contain an acknowledgment on the part of the FQHC or RHC that the nonhospital site must report GME c nonreimbursable GME costs center.

—indicate that portion of time the physician spends training residents in the FQHC or RHC.

● "Reasonable" Compensation

The statute requires that a hospital incur "all or substantially" all of the training costs while the resident is train nonhospital site for the hospital to be able to count the resident for indirect and direct graduate medical education. defines "all or substantially all" to mean that the hospital is incurring the cost of the resident compensation and pr reasonable compensation for supervisory teaching activities. The determination of what constitutes reasonable cor matter between the hospital and nonhospital site. If there is a written agreement between the hospital and the nonh to the compensation which will be provided for supervisory teaching activities, the fiscal intermediary may includ training in the nonhospital site for indirect and direct graduate medical education. However, the written agreement reflective of the actual costs incurred for resident compensation and supervisory teaching activities. We do not exp intermediaries to do a detailed cost finding as to each party's respective costs. However, if there is evidence that a incurring costs consistent with the written agreement, the fiscal intermediary should not allow the resident to be in hospital FTE counts for indirect and direct graduate medical education.

● Situations Where the Nonhospital Site May Have No Supervisory Teaching Costs

The written agreement may indicate that the hospital is providing reasonable compensation for the cost incurre nonhospital site for supervisory teaching activities or that hospital itself is incurring these costs. There may be inst the hospital is incurring the costs of supervisory teaching activities. For example, physicians supervising the resid nonhospital site may be employees on staff at the hospital or the hospital may contract with physicians for a variet including supervision of residents in nonhospital sites. In these instances, the written agreement between the hospi nonhospital site must indicate that the nonhospital site does not have any teaching physician costs because these c incurred directly by the hospital.

The teaching physicians may also be on the staff of a medical school with a payment being made from the hosp medical school for supervisory teaching physician activities performed in both hospital and nonhospital sites. In th there must be an acknowledgment on the part of the nonhospital provider, as part of the written agreement with th it does not have supervisory teaching costs for the hospital to be able to count the resident for indirect and direct g medical education. This situation is distinguished from one in which the medical school is incurring the cost of the physician salary in the nonhospital site and there is no payment from the hospital to the medical school for these c latter situation, the hospital is not incurring all or substantially all of the costs and cannot count the resident for ind graduate medical education.

As indicated above, resident training may take place in a variety of nonhospital settings including freestanding homes and physician offices. There may be situations where the supervising physician and the nonhospital site are same (e.g. a physician in private practice in an office practice). In this instance, the written agreement would be be hospital and the private practice physician. In other situations, a private practice physician may be providing super resident in a distinct nonhospital site (e.g. a nursing home). The hospital may be providing compensation to the ph supervisory activities and the nonhospital site does not have these costs. Again, this is a situation where there mus agreement between the hospital and the nonhospital site where the nonhospital site acknowledges that it does not h physician costs.

● Travel and Lodging Expenses

There may also be situations where a hospital or, alternatively, the nonhospital site is directly incurring travel a costs site associated with the resident's training outside of the hospital. In these situations, the travel and lodging c resident compensation. If resident compensation is being provided in the form of travel and lodging, the written ag

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

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

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

Submitter : Mr. Tim Johnson **Date:** 03/26/2007

Organization : Greater New York Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

See attached.

CMS-1529-P-123-Attach-1.PDF

#123

Greater New York Hospital Association
555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
Kenneth E. Raske, President

March
Twenty-Six
2007

Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard,
Attention: CMS-1529-P, Mail Stop C4-26-5
Baltimore, MD 21244-1850

RE: Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes (*Federal Register* 72, no. 21, February 1, 2007)

Dear Administrator Norwalk:
Greater New York Hospital Association (GNYHA), which represents approximately 100 teaching hospitals in the metropolitan New York region, including hospitals in New York, New Jersey, Connecticut, and Rhode Island, welcomes the opportunity to provide these comments on the graduate medical education (GME) discussion within the Medicare proposed rule that was published in the *Federal Register*, Vol. 72, no. 21, on February 1, 2007. This discussion dealt specifically with resident training in nonhospital settings and a proposed alternative methodology that would enable hospitals to count that training for Medicare reimbursement purposes.

GNYHA is extremely appreciative that, within the Balanced Budget Act (BBA), Congress chose affirmatively to recognize nonhospital settings as an integral part of residency training that should be recognized for direct GME and indirect medical education (IME) reimbursement. While the GNYHA member teaching hospitals and other members of the academic medicine community have in the past disagreed with certain regulatory interpretations that the Centers for Medicare & Medicaid Services (CMS) has put forth concerning physician resident training in these settings, we are confident that we can work with CMS ("the Agency") to craft a policy that serves the interests of teaching hospitals, the nonhospital organizations, physician residents, and the Medicare beneficiaries they serve. This CMS proposed rule is a fine first step in crafting that more sensible policy and we welcome the opportunity to comment on it.

Section I: General Comments on the Proposed Rule
In the context of this rulemaking, GNYHA respectfully offers the following general comments regarding administrative burdens, the potential deleterious effects of complex policymaking in this area, and the general nature of resident training activities.

Administrative Burdens
GNYHA and its member teaching hospitals appreciate that CMS has met with industry representatives on numerous occasions and is now seeking to craft an alternative methodology that would address concerns raised by the industry. In particular, we appreciate that CMS has heard and understood that the numerous educational relationships between teaching hospitals and affiliated nonhospital settings demand a simpler means of addressing the administrative burdens being placed on these organizations. GNYHA also applauds the willingness of the Agency to offer the use of agreed-upon proxies as an alternative to conducting burdensome site-specific, specialty-specific, and physician-specific time studies and calculations that may serve the goals and intent of the underlying statute, but are all but impossible to work with.

In the context of what this proposed rule intends to accomplish, GNYHA encourages CMS to ensure that its alternative methodology does not create alternative but equivalent – or perhaps more significant – administrative burdens for organizations seeking to utilize it. As CMS has heard on numerous occasions in the context of meetings and in response to the Agency's rulemaking, the complexity of documentation requirements associated with GME has become overwhelming. Upon audit by CMS's contractors, teaching hospital finance and program staff are being asked to provide more and more documentation in order to ensure that the contractors do not disallow the Medicare GME reimbursement dollars to which these hospitals are entitled.

If, therefore, the response from the industry regarding particular components of this proposed rule is that the proposal is merely substituting one set of burdensome requirements for another, GNYHA encourages the Agency to seriously consider industry suggestions for simpler "shortcuts or proxies" (to use the Agency's phrase) or, alternatively, the publication of an interim final rule with comment period to solicit additional feedback from the industry on specific components of the policy.

Effective Date of Policy
CMS is soliciting comments regarding the effective date of this "new rule." Given the difficulties that teaching hospitals have had with CMS's previous statements regarding its regulations in this area, GNYHA would be appreciative if this policy was characterized not as new rule with a prospective effective date, but as a "clarification of existing policy." Teaching hospitals and CMS's contractors are looking for clear guidance on these issues, and it serves no good purpose to pick an arbitrary point in time and change the policy in a manner that creates a false distinction between the treatment of previously submitted cost reports and current or future cost reports. Should the Agency be unwilling to adopt such a stance, GNYHA would be supportive of an effective date of July 1, 2007 (including portions of cost-reporting periods). We note again, however, that should there be outstanding issues that still would benefit from further industry input, GNYHA would support the publication of an *interim* final rule effective July 1, 2007, with additional comment period.

Promoting Training in Nonhospital Settings
While GNYHA is extremely appreciative that CMS is attempting to simplify the documentation and audit burden on teaching hospitals, it would be most unfortunate if the Agency wound up

with a rule that encourages hospitals to pull as many residents back within the four walls of the hospital as possible to avoid those burdens.

The accrediting bodies for residency training have continued to modify their specialty-specific minimum standards in response to the forces driving changes in the type of patient care that is needed for what were once major and risky procedures, and to ensure that physician residents receive appropriate training in nonacute care settings. By including language within the BBA that permits teaching hospitals to claim resident training time in nonhospital settings for Medicare IME in addition to direct GME, Congress explicitly eliminated a major barrier to teaching hospitals rotating their residents to these nonhospital settings. However, the accrediting body minimum standards, while specifying the *type* of training, generally do not specify the *location* of the training. This is an important distinction in the context of Medicare GME payment policy.

It is rare for a residency review committee (RRC) to specify that non-acute experience must take place "outside the four walls of the hospital" and it would be unheard of for an RRC to specify that a nonacute care experience must take place "at a site that is not included within the hospital's Medicare provider number." As CMS is aware, major teaching hospitals often house large outpatient departments and clinics within their four walls. The intent of the BBA's change in IME payment policy was not just to encourage and support more training in nonacute care settings but also to encourage and support training in nonhospital settings.

This distinction is critically important because compliance with the Agency's policy statements in this area has been challenging since the passage of the BBA. As a result, GNYHA teaching hospitals have noted anecdotally that the complexity and uncertainty associated with the documentation and audit issues may very well force teaching hospitals to create and reconfigure more training opportunities to occur within their four walls. That would be a most unfortunate result. To avoid such an occurrence, the Agency should ensure that the general standard within this rulemaking does indeed ease the administrative complexity that the industry is seeking.

Parsing of Physician Resident Training Activities
Within this comment letter, we must also again reiterate our disagreement with CMS's view that the Agency is somehow required under the statute to assess the exact nature of particular physician resident activities. These general comments were raised previously in the context of GNYHA's comments regarding the Agency's "didactic activities" clarification as part of the Federal fiscal year 2007 acute inpatient rulemaking.

Physician resident training is a fluid activity that comprises direct patient care, educational activities related to patient care, and research activities intended to support patient care. Except in certain specific and limited cases (e.g., a defined bench research assignment), the activities blend together to form a seamless whole that is not amenable to the parsing that the Agency seeks to perform, and this degree of parsing was never intended or expected by Congress.

GNYHA recognizes that the Agency's role is to ensure that its regulations reflect Congressional intent, and because statutory language is sometimes imprecise, the Agency must make difficult decisions that might come down to the meaning and use of a couple of words. That being said,

GNYHA continues to believe that in the case of the Medicare direct GME and IME statutory language concerning nonhospital settings, there is ample room for a more general reading, and CMS has elected to parse sentences unnecessarily and inappropriately. The effect of this semantic exercise is the "parsing" of physician residency training activities in a manner that was not intended by Congress.

Section II: "All" vs. "All or Substantially All"

GNYHA appreciates and supports that CMS now recognizes that there is a distinction between "all" and "all or substantially all" (the exact language in the statute) and has proposed to establish a more reasonable requirement for hospitals to demonstrate incurring of direct GME costs at the nonhospital setting. GNYHA also appreciates and supports the Agency's recognition that such a distinction should apply both in the case of a hospital using agreed-upon proxies and in the case of a hospital using its own actual documented time studies.

While GNYHA does support this recognition on the part of the Agency, we do question the selection of 90% as the appropriate threshold percentage. GNYHA would not have expected that the Agency's interpretation of the word "substantially" would yield such a high percentage. Consistent with the thoughtful recommendations made by our colleagues at the Association of American Medical Colleges (AAMC), GNYHA supports the adoption of 75% as an appropriate threshold percentage for "substantially all."

Section III. Implementation of 90% Cost Threshold

GNYHA appreciates that CMS has devised a methodology using proxies that the Agency believes will relieve the administrative burdens associated with this component of the Medicare direct GME and IME regulations. Again, we applaud the Agency's recognition that an alternative methodology and these proxies are needed to alleviate the severe administrative burdens on teaching hospitals. GNYHA's specific comments are intended to support the overall goal of relieving some of that burden.

National Average Physician Salary

The stated goal for CMS is to provide a set of proxies to be used that will permit an administratively simple alternative to having to gather specific supervising physician salary information. GNYHA appreciates that CMS is willing to grant the hospitals the ability to use proxies and has several comments on specific features of this methodology.

Prorating of Supervising Physician Salary Data

Consistent with the proposed alternative methodology, GNYHA understood that CMS would permit certain logical adjustments to be made in the application of the methodology in recognition of variations in scheduling. Teaching hospitals and nonhospital settings enter into different educational arrangements for a variety of reasons not relevant to the issues raised in this rulemaking. It is thus with dismay that GNYHA has recently understood from industry colleagues that the Agency may somehow be planning to view the application of the methodology differently depending on schedules and the duration of certain activities.

In particular, we understand that CMS may be seeking to make a distinction in the use of pro-rating techniques for supervising physician salary data in certain cases. We understand that, for

purposes of this rulemaking, CMS may be making a distinction between, for example, a physician resident engaged in six consecutive months of full-time activities and a physician resident engaged in twelve consecutive months of half-time activities. We understand that in the former case, CMS may permit a pro-rating of the supervising physician's salary (to 50%) and in the latter case, may require the hospital to perform a calculation based on 100% of the supervising physician's salary. GNYHA does not believe there is any basis for this distinction. In both cases, a physician resident is spending 0.5 FTE of his time at the nonhospital setting – the teaching hospitals should not have to incur any additional costs based on the exact nature of the scheduling if the sum of the assignments for the physician resident on an FTE basis is the same.

Sources of Data

GNYHA does not have a specific opinion regarding the source of the physician salary data. We do, however, strongly recommend that the Agency ensure that it is able to publish the physician salary information each year so that the contractors and the hospitals can all refer to the same source in determining whether compliance with Medicare regulations has been met.

Blended Primary Care and Non-Primary Care Salary Figures

In the interest of administrative simplicity, GNYHA recommends that CMS permit teaching hospitals to use two "blended" supervising physician salary amounts – one for primary care and one for non-primary care – to further simplify the process of identifying proxies. That is, the hospitals should be permitted to create two distinct blended figures from the published salary data and use those amounts for all nonhospital training rotation. The calculation of the blended figures (i.e., which salaries to blend) could be based on a periodic survey of the supervising physician complement in place at each of the nonhospital training sites.

Mean vs. Median of the Physician Salary Figures

GNYHA recommends that CMS use the median of whatever physician salary data are selected as the basis for the proxy. The use of the mean would be acceptable if there were no expected outliers, there were a general normal distribution of the salary amounts, and the data points had something of a natural (normal) floor or ceiling. In the case of physician salary information, while there is a natural floor, there is no natural ceiling since certain physicians' salaries might be significantly outside the usual range and these figures could skew the results. Since the goal of using proxies is to identify a single and representative figure that might be used by teaching hospitals, GNYHA recommends the use of the median as the appropriate figure.

Single National Figure vs. Geographic Variations

Since the goal of this proposal is to create a set of simple proxies, GNYHA would not support the use of more than one single national figure for each specialty (and that figure should be the median salary, as noted above). Within specialties, GNYHA has not identified significant regional variations, and any large variation that might exist would be accounted for by simply using the median. As with all analyses of data, the larger the data set, the better, and GNYHA is concerned that some of the specialty physician salary averages would be questionable if the data set used was made up of information gathered solely in one region.

Section IV. Inclusion of Detailed Information in the Written Agreements
Given the goal of easing administrative burdens, GNYHA was disappointed that CMS stated in its proposed rule that the written agreement between the teaching hospital and nonhospital setting "should specify the total amount of nonhospital site training costs the hospital will incur and specify what costs are included in that amount because the hospital would need to determine up front the amount it must pay to the nonhospital site in order to meet the 90 percent threshold..." (*Federal Register*, page 4828). CMS notes that including this information in the agreement "will simplify the audit process."

While the inclusion of this information in the written agreement might simplify the audit process, it certainly will not simplify the preparation of the written agreements. The idea that it would be necessary to include a complex calculation regarding the derivation of a cost amount and whether it meets a certain threshold for reimbursement within a contract between two parties is quite surprising. GNYHA recognizes the need for this information to be *available* upon audit, but strongly encourages CMS to not require that it be included within the written agreement.

Section V. Global Agreements Between Medical Schools and Teaching Hospitals
GNYHA notes that the helpful examples that CMS has provided as part of the preamble to the proposed rule are simple and illustrative, but are not representative of a good number of the complex arrangements that teaching hospitals currently have in place to support the delivery of nonhospital setting training to physician residents. In particular, many teaching hospitals currently have global agreements in place with medical schools that formally sponsor faculty practice plans or clinics in which physician residents are trained. These global agreements form the basis of teaching hospitals' institutional and financial support for their affiliated medical schools. These global agreements, as their name implies, cover numerous sites and numerous physicians in numerous specialties, and are designed to provide an administratively simple means for teaching hospitals to compensate the medical school.

Unfortunately, CMS notes in its proposed rule that "[g]lobal agreements with lump sum payment amounts, either for teaching physician costs or for nonhospital training in general, have not been sufficient under existing policy and would not be sufficient under the proposed policy" (*Federal Register*, page 4829). In that case, the Agency's stated purpose in attempting to simplify matters and relieve administrative burdens has not been achieved at all in a large number of instances. Through the issuance of an interim final rule with comment period, CMS should solicit additional comments on an acceptable methodology to specifically identify a means to ensure that global agreements between teaching hospitals and medical schools can be used to simplify the administrative complexity of this regulation and address the intent of the statute as CMS sees it.

Section VI. Clarification Regarding Reporting Resident FTEs Over the FTE Cap

A number of GNYHA member teaching hospitals train residents in excess of their Medicare full-time equivalent (FTE) resident cap amounts. In the context of this rulemaking and certain issues that are presented, GNYHA requests formal clarification regarding whether teaching hospitals are required under CMS regulations to report resident rotations (that is, on an FTE basis) in excess of their hospital-specific Medicare cap amounts. The concerns that we have are twofold.

First, GNYHA is concerned that should a hospital include certain residents training at nonhospital settings in their formal resident FTE counts, but elect not to complete Medicare-required written agreements (because the hospital will not be reimbursed for the resident FTEs regardless of compliance), CMS's contractor may still sample from among the "excess residents" for audit purposes and extrapolate to an audit disallowance that would be far in excess of just that sampled resident. For this reason, GNYHA would initially recommend that CMS concur that such reporting is not necessary.

However, GNYHA is concerned that Congress may elect in a future year to legislate another "Section 422" program that would recognize hospitals training residents (and paying their salaries and benefits) in excess of their FTE resident caps and hospitals that did not report these residents would be unfairly disadvantaged. For this reason, we agree with our colleagues at the AAMC that it would be appropriate to have hospitals include these residents on their cost reports, but on a separate line that clarifies that they are not to be "included" for reimbursement or audit purposes because all regulatory requirements associated with the resident training have not been met. That is, the residents are training in what would be Medicare-reimbursable approved programs, but are not eligible for Medicare direct GME and IME due to certain additional requirements included within the regulations. In this way, in the event that Congress passes a much-needed law that provides some sort of resident cap relief, hospital cost reports would reflect an accurate count of the total number of residents for which the hospital is paying the residents' salaries and benefits.

Follow-Up
Thank you for the opportunity to submit these comments. Should your staff have any questions, they should feel free to contact me at 212-506-5420 or tjohnson@gnyha.org.

Sincerely,

Tim Johnson

Tim Johnson
Vice President, Finance and Graduate Medical Education

Attachment

#123

HUNTER

Department of Economics

Partha Deb
Professor
(212) 772-5435
partha.deb@hunter.cuny.edu
http://urban.hunter.cuny.edu/~deb

March 26, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Ave, SW
Washington, DC 20201

Attention: **CMS--1529—P: PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION**

Dear Administrator Norwalk:

In the context of the Centers for Medicare & Medicaid Services (CMS) proposed rule regarding Medicare direct graduate medical education (GME) and indirect medical education (IME) payments for physician resident training in nonhospital settings, I have been asked by the Association of American Medical Colleges (AAMC), the Greater New York Hospital Association (GNYHA) and the American Osteopathic Association (AOA) to perform a review and analysis of certain available data that have been used by CMS as a basis in the proposed rule for the selection of a "proxy" in lieu of hospital-specific determinations. This proposed proxy – three hours – would set a "presumed standard number of hours spent by teaching physicians in nonpatient care GME activities in every nonhospital site" (*Federal Register*, vol. 72, no. 21, page 4826).

I am a health economist associated with the Economics departments at Hunter College and the Graduate Center, City University of New York, and with the National Bureau of Economic Research. I was formally trained as an econometrician and my own research in the economics of healthcare involves sophisticated statistical modeling and analysis of healthcare utilization, expenditures, costs, and of health outcomes. In addition to being engaged in my own active research agenda, I am called upon, from time to time, to provide reviews of survey and statistical methodology, and to provide statistical analyses of data. It is in this latter role that I write this letter to you.

Summary of Analysis
My analysis of the data reveals that CMS has drawn extremely questionable conclusions from the available data sources. Specifically, my analysis reveals that:

1. There are two major problems with the available data sources. First, the response rates are extremely low and cannot be considered scientific by any standards. Second, there is clear evidence that a number of respondents may not have understood the nature of the questions. In general, this data should not be used as the final word in determining a proxy that would form the basis for a Medicare payment policy decision.

2. Given the gross unreliability of the data, CMS should engage in a rigorous study prior to the final determination of a proxy for the number of hours spent by teaching physicians in nonpatient care GME activities in nonhospital sites.

3. If CMS wished to identify a usable proxy until this more rigorous study could be performed, based on the available data, a proxy of two hours is much more supportable by the data than the three hours that CMS identified in the proposed rule.

Background

According to the proposed rule (*FR*, page 4826), the determination of the proposed proxy is based on "informal surveys" conducted by four organizations – the AFMAA, the AOA, the AAMC, and CMS.

In coordination with GNYHA, the AFMAA and the AOA shared their survey methodology and collected data with me so that a review of the methodology and a statistical analysis of the data could be performed. The AAMC did not share any data and reported to me that the organization has never conducted a survey on this topic nor shared any results with CMS. No "information compiled from [CMS's] own informal surveys of teaching physicians" was shared with me and I understand it was not made available to the public.

Therefore, my analysis relied on data from two surveys – the AOA survey and the AFMAA survey. The AOA data consisted of 36 responses to a nationwide survey. Given the extremely small number of responses, it is fair to say that these data must be characterized as extremely unreliable. The AFMAA data, while also limited due to a very low response rate (less than 1% based on AFMAA staff estimates), are based on almost 150 responses and are thus a better available source of data. This data therefore formed the basis of my statistical analysis.

Analysis of the AFMAA survey data

An analysis of the distribution of the number of hours per week spent on non-patient related GME presented below in Table 1 shows that, although the sample mean is over 3 (4.4), the median is 2.125. Thus the data are extremely skewed (this can also be seen from the skewness statistic in Table 1). In such situations, the median is considered to be a much more reliable measure of central tendency than the mean.

Table 1

hours per week spent on non-patient related GME

	Percentiles	Smallest		
1%	0	0		
5%	0	0		
10%	0	0	Obs	158
25%	.5	0	Sum of Wgt.	158
50%	2.125		Mean	4.367089
		Largest	Std. Dev.	6.663349
75%	4.5	26		
90%	11	28.5	Variance	44.40022
95%	20	32	Skewness	2.836384
99%	32	40	Kurtosis	11.68137

Hunter College of The City University of New York, 695 Park Avenue, New York, NY 10021
Phone (212) 772-5400/5401 Fax (212) 772-5398
Web: econ.hunter.cuny.edu

Indeed 13 observations of this sample of 158 have inconsistent responses because the number of hours on one of the two activities that make up number of hours per week spent on non-patient related GME are greater than the total number of hours reported for effort at that site. It is reasonable to assume that such observations are unreliable and are better dropped from the analysis.

An analysis of the sample with consistent responses, reported in Table 2 below, shows a decrease in both the mean and median. The mean continues to be substantially larger than the median and the skewness statistic is still very large. Thus, the median continues to be the preferred measure of central tendency.

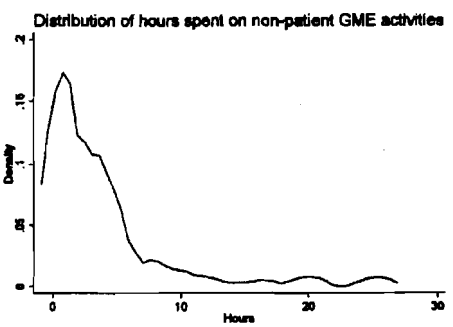
Table 2

hours per week spent on non-patient related GME

	Percentiles	Smallest		
1%	0	0		
5%	0	0		
10%	0	0	Obs	148
25%	.5	0	Sum of Wgt.	148
50%	2		Mean	3.677365
		Largest	Std. Dev.	5.080914
75%	4.125	20		
90%	9	25	Variance	25.81569
95%	16	25	Skewness	2.537888
99%	25	26	Kurtosis	9.89343

A more visual way to show the extreme skewness of the distribution of hours per week spent on non-patient related GME is obtained by plotting its distribution. This is shown in Figure 1 alongside. It clearly demonstrates why the sample mean is heavily influenced by a few large values of reported hours.

Figure 1



One may reasonably wonder if the CMS-proposed of 3 hours is substantially different from 2 hours, which is the estimated median in the sample. A statistically sophisticated way to address this issue is by the use of bootstrap methods. The bootstrap method allows an analyst to mimic repeated sampling from the population. Thus it becomes possible to ask how likely a median of 3 or greater would be if such a survey were conducted repeatedly. I conducted such an analysis of the data and report my findings below.

First, a univariate analysis of the results from bootstrap resampling, reported below in Table 3, shows that the 95% confidence interval of the median does not include 3. Indeed, it is very unlikely that 3 would ever be the estimated median number of hours per week spent on non-patient related GME.

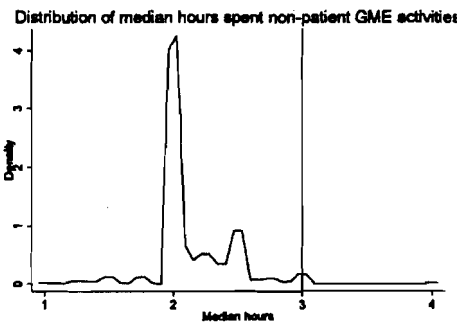
Table 3

Bootstrap results — Number of obs = 148; Replications = 1000

	Observed Coef.	Bootstrap Std. Err.	z	P>|z|	Normal-based [95% Conf.	Interval]
median	2	.3055317	6.55	0.000	1.401169	2.598831

A more visual way to present this information is by plotting the distribution of the median of hours per week spent on non-patient related GME. Figure 2 below shows, again, how unlikely it is that the median would actually be 3 or greater. Indeed most of the distribution is tightly clustered around 2 with some non-negligible frequency observed up to 2.5. Beyond 2.5, the frequency of observed median values is virtually negligible.

Figure 2



Conclusion

Given the importance of this proxy, I think it is imperative that CMS conduct a more formal study before settling on *the* final proxy that should be used for the number of hours spent by teaching physicians in nonpatient care GME activities in every nonhospital site in lieu of hospital-specific analyses. The currently available surveys are undoubtedly unreliable along a number of dimensions. In the meantime, if CMS does wish to permit hospitals to use a proxy in lieu of a hospital-specific analysis, CMS should establish a proxy of two hours since the single best available source of data (from AFMAA) – albeit limited – supports that number more than CMS's proposed three hours standard.

Should you wish to discuss anything related to this letter, please feel free to contact me via email at partha.deb@hunter.cuny.edu or by phone at 212 772 5435.

Sincerely,

Partha Deb

Partha Deb, PhD
Professor
Department of Economics
Hunter College and the Graduate Center
The City University of New York

and

Research Economist
National Bureau of Economic Research

Submitter : Ms. Ann Langan **Date:** 03/26/2007

Organization : St. Cloud Hospital

Category : Hospital

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

CMS has asked for comments on whether to use the mean or median compensation amounts for purposes of determining the teaching physicians' cost. We ask that CMS use the median compensation amounts rather than the mean. Also, we ask CMS to recognize the geographic variations in the salary amounts within each specialty and not just use a single national average for each specialty.

We also ask CMS to clarify what items would be allowed to be considered to be fringe benefits of the interns/residents.
We are wondering if the cost of continuing education for the interns/residents would be considered to be a fringe benefit.

Submitter : Mr. Steven Kowske **Date:** 03/26/2007

Organization : Aurora Health Care

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

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

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

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

Submitter : **Ms. Elizabeth Cobb** **Date: 03/26/2007**

Organization : **Kentucky Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1529-P-126-Attach-1.DOC

#126

Kentucky Hospital Association

Representing Kentucky Health Care Organizations

March 26, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: (CMS–1529–P) Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes, (Vol. 72, No. 21), February 1, 2007

Dear Ms. Norwalk:

On behalf of all hospitals in the Commonwealth of Kentucky, the Kentucky Hospital Association (KHA) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS) proposed changes to the long-term acute care hospital (LTACH) prospective payment system (PPS). We are concerned about the expansion of the 25% Rule on patient referral as well as proposed changes to the short-stay outlier policy; however, we support the proposal to re-weight the LTACH diagnosis-related groups (DRGs) in a budget-neutral manner.

Expansion of the 25% Rule on Patient Referral Sources

In its fiscal year (FY) 2005 rule, CMS implemented payment limitations for LTACHs that are co-located with other hospitals in response to concerns about "inappropriate patient shifting" between acute care hospitals and LTACHs. Under the rule, when an LTACH is co-located with another hospital, no more that 25 percent of the LTACH's admissions from the co-located hospital will be paid at the full LTACH prospective payment rate. If the LTACH receives more than 25 percent of its admissions from the co-located hospital, the LTACH payments will be reduced for those patients exceeding the limit. CMS adopted the 25% Rule, in part, to address its concern that locating an LTACH within an acute care hospital might encourage the shifting of patients from host hospitals to co-located LTACHs for financial – rather than medically appropriate – reasons.

As part of its annual LTACH PPS payment update for 2008, CMS proposes to extend the 25% Rule to all LTACHs, including freestanding and satellite facilities, as well as LTACHs that were exempted from the original 25% Rule. To accommodate LTACHs located in rural areas or in metropolitan statistical areas (MSAs) served by one or more "MSA dominant hospitals", the agency increases the referral limitation to 50 percent. **The KHA believes this model of limiting the percentage of patients referred by a single source is an illogical solution to perceived inappropriate patient shifting and does not address the appropriateness of patient selection and quality of care.**

Congress introduced LTACHs into the health care system to address a gap in the continuum of care for our sickest patients, those requiring long-term, medically complex treatment. The intent of Congress was to address quality of care needed to treat these unique patients. CMS' proposal to expand the 25% Rule is not a quality-driven decision and does not address the concerns raised regarding inappropriate patient referral. In fact, no other post-acute care setting requires a location-based methodology. LTACHs admit patients referred from the short-term acute care setting much like rehabilitation hospitals and skilled nursing facilities; however, LTACHs are singled out by being held to a threshold on patient referral sources.

Kentucky is a largely rural state with more than half of the counties designated as rural. CMS' proposal to address the special challenges related to referral of patients in rural areas by increasing the 25 percent threshold to 50 percent does little to alleviate the problems associated with largely isolated hospitals. In our examination of the effect of the current 25% Rule on co-located LTACHs, we have found that it is impossible for many of facilities located in *metropolitan* areas to meet the threshold. Free-standing LTACHs located in isolated, rural areas certainly will not be able to continue to provide this needed services if the proposed rule is finalized.

A great number of our facilities are located many miles from another referring facility. Additionally, one-third of Kentucky's short-stay acute hospitals are designated as critical access hospitals. These small, safety-net hospitals do not refer substantial numbers of patients to LTACHs as do the few, larger short-stay acute hospitals serving a rural region. The high number of very small facilities coupled with distantly located larger, referral centers makes it impossible to meet the 25% or 50% Threshold. The loss of the few, needed facilities already established in Kentucky will result in a reappearance of the gap in health care services for our sickest citizens which Congress attempted to address in establishing the LTACH PPS. Additionally, the proposal discourages the establishment of any new LTACHs in the Commonwealth needed to serve in areas which remain underserved.

Based on these circumstances affecting Kentucky hospitals and hospitals across the nation, we urge CMS to discontinue the agenda to limit access to LTACH services through payment cuts. Rather, the KHA proposes CMS consider addressing appropriate patient selection as identified by the Research Triangle Institute (RTI) in a 2006 report solicited by CMS. This report identified feasible patient and facility criteria that would help distinguish LTACHs from other acute care facilities and help ensure appropriate patient selection and referral.

Short-Stay Outliers

The KHA is aware of comments subrnitted by the American Hospital Association. The KHA fully supports the AHA's position on proposed changes to the short-stay outlier policy.

Kentucky Hospital Association

Representing Kentucky Health Care Organizations

Budget Neutral Re-Weighting of the LTACH DRGs

The LTACH DRGs may be re-weighted in a non-budget-neutral manner – a method that CMS utilized in FY 2007 to reduce Medicare payments to LTACHs and in an attempt to stabilize LTACH coding practices. In the proposed rule, CMS recommends that the annual re-weighting of the LTACH DRG be conducted on a budget-neutral basis, beginning October 1, 2007. This provision would be included in the FY 2008 proposed and final rules for the inpatient PPS. The agency is proposing this change since analysis of claims from FYs 2003 through 2005 indicates that LTACH coding practices have stabilized, and therefore, the most recent case mix increases are primarily due to higher patient severity rather than coding behavior, which had been identified as the primary cause in prior years. **The KHA strongly supports re-weighting the LTACH DRGs in a budget-neutral manner and urges CMS to move forward with this proposal.**

Thank you again for the opportunity to comment. If you have any questions, please feel free to contact me at (502) 426-6220 or by email at ecobb@kyha.com.

Sincerely,

Elizabeth G. Cobb

Elizabeth G. Cobb
Director/Health Policy

Submitter : **Mr. Richard Umlor** **Date: 03/26/2007**

Organization : **Respironics**

Category : **Device Industry**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-1529-P-127-Attach-1.PDF

#127

RESPIRONICS

March 26, 2007

Hon. Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1529-P
Mail Stop C4-26-5
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: ***Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes; Proposed Rule, 72 Fed. Reg. 4776 (February 1, 2007)***

Dear Ms. Norwalk:

This letter represents Respironics' position in support of the comments and recommendations submitted to you dated March 23, 2007 from the Acute Long Term Hospital Association ("ALTHA") to certain aspects of the proposed annual payment rate updates and policy changes under the prospective payment system for long-term acute care hospitals ("LTACH PPS") for rate year ("RY") 2008, which were published by the Centers for Medicare & Medicaid Services ("CMS") on February 1, 2007.

Respironics believes that ALTHA has provided accurate and meaningful data to support their position on the proposed changes and that CMS should carefully reconsider their policies advanced in the proposed rule. We support ALTHA's position that LTACHs serve a distinct and important purpose in the healthcare continuum and that CMS's payment policies should reflect this in a manner that fairly compensates LTACHs for the care they provide to Medicare beneficiaries across the nation. We believe that CMS should consider the data and analyses that ALTHA submitted in their comments and collaborate with ALTHA to establish a more effective set of proposals to better define the patients, setting and reimbursement policies for long-term acute hospital care.

Sincerely,

Richard J. Umlor
Vice President, Strategic Accounts

Submitter : Mr. Mark Greene **Date:** 03/26/2007

Organization : POH Medical Center

Category : Hospital

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

Coming out with a rule in 1999 and then changing(clarifying) the rule in 2004 with retroactive enforcement to 2001 is unethical. We can save our physicians hundreds of thousands of dollars by offering CEU'S. Why would this not be considered as payment(payment is not synonymous with only cash)? If a physician wants to volunteer, they should be able to. It's a waste of money to have thousands of physicians around the country attest as to the amount of money they make in their practice($ per hour). If CMS is going to further clarify an old rule and make payment mandatory, why not just say it has to be a minimum $60 per hour. This is much more efficient than the proposed rule. The cumulative resources wasted nationally on this issue is a joke. It's a waste of Physicians,Secretaries,Lawyers,Consultants,CFOs,Reimbursement staff,Auditors and Director of Medical Educations time. The paperwork required to pass an audit(even if the rules were known) is enormous. What ever happened to the Paperwork Reduction Act? If you want to know why "Healthcare Gone Wild" is approaching 20% of GNP, you need to look no further than the Federal Register. If you have any questions, please feel free to call me @248-338-5050. Sincerely, Mark Greene p.s. It was never the intent of Congress to require this. Please see attachment.

CMS-1529-P-128-Attach-1.PDF

#128

Congress of the United States

Washington, DC 20515

[redacted]

The Honorable Mark McClellan, M.D., Ph.D.
Administrator, Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Administrator McClellan:

[redacted]

Since 1987, hospitals have been allowed to count the time residents spend in non-hospital settings for the purpose of direct graduate medical education (DGME) payments, subject to agreements between the hospital and the non-hospital site where training occurred. Congress expanded this policy to include payment for indirect medical education (IME) in the Balanced Budget Act (BBA) of 1997 as long as the teaching hospital incurred "all or substantially all" of the costs.

[redacted]

[redacted]

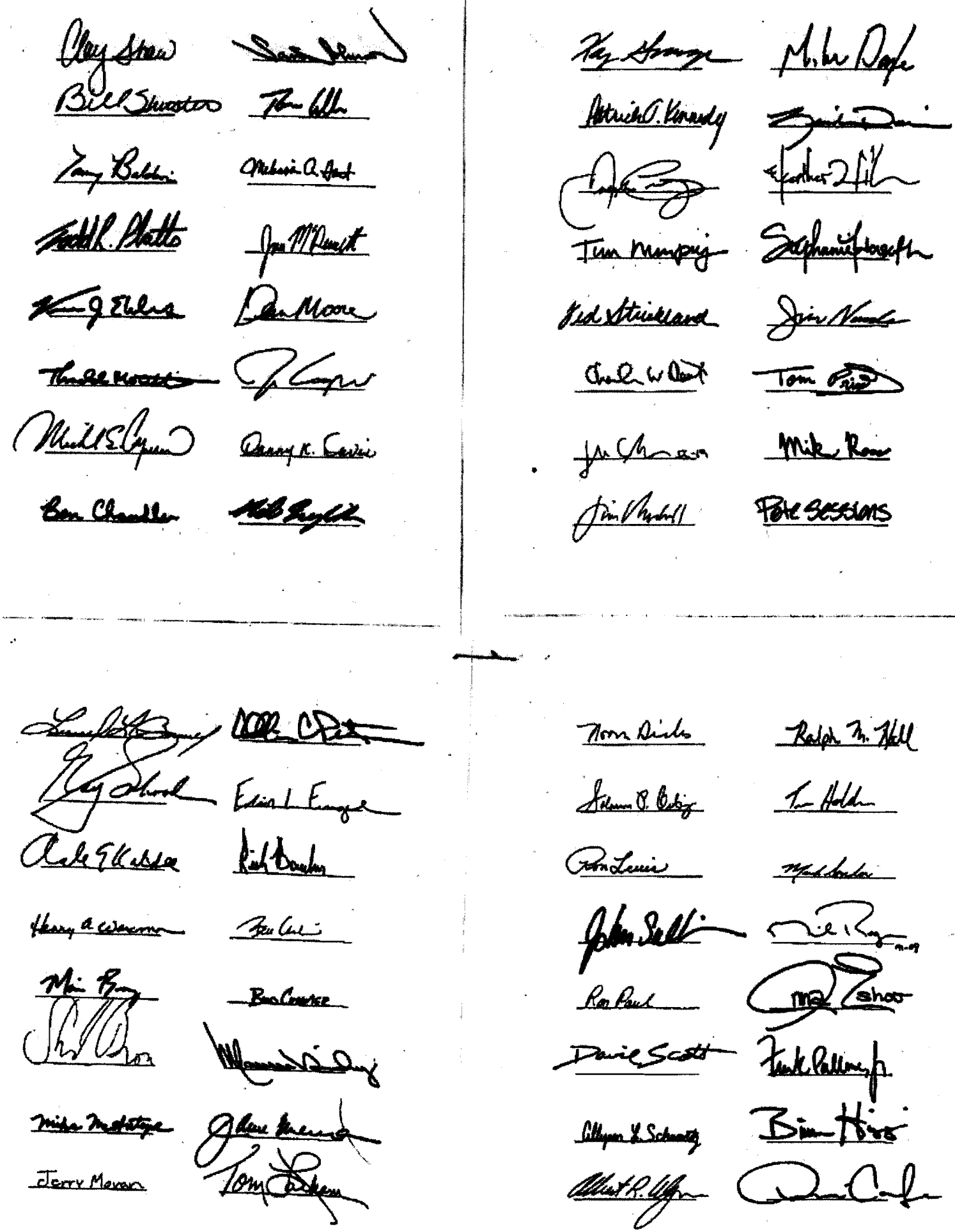
[redacted] Section 713 of the Medicare Modernization Act (MMA) called for a one-year moratorium that expired in December 2004 on payment denials. Likewise, the Office of the Inspector General (OIG) of the Department of Health and Human Services was required to conduct a study on residency training in nonhospital settings and to issue a report identifying alternative payment methodologies for the costs of training residents in those settings.

[redacted]

[redacted]

Thank you in advance for your attention to this matter. We look forward to receiving a timely response.

Sincerely,



Submitter : Mrs. Sharon Hall **Date:** 03/26/2007

Organization : Charleston Area Medical Center

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-1529-P-129-Attach-1.DOC

#129

COMMENTS ON PROPOSED RULE FOR DGME AND IME PAYMENT POLICIES RELATED TO RESIDENTS IN NON-HOSPITAL SETTINGS

We appreciate the effort of CMS to further define standards for written agreements and policies related to residents time in non-hospital settings. A more clear definition has been long coming and awaited by our institution. While the statute intended by Congress in 1987 did not choose to define this statement, CMS has interpreted the phrase "all or substantially all" costs more specifically and inconsistently in recent years. The overall impact of these decisions has and will continue to cause disincentives for training at non-hospital sites which is contrary to the original intent of Congress in the statute. Over the past two years, we have decreased opportunities for non-hospital training and physicians who feel more subjected to government scrutiny are declining to participate in training.

For the current academic year, 107 (80%) residents from our institution will experience at least a one month rotation assignment at a non-hospital site (NHS) as it is currently defined by CMS. They will receive training predominantly in teaching clinics at our affiliated medicaal school, physician private practice offices, nursing homes, a free health clinic, and rural Federally Qualified Health Centers in our area. Although assigned to a NHS for a rotation, on any given day, residents will enter in and out of these settings at the will of the supervising physician—coming back and forth into the teaching hospital or the office/clinic setting. Most sites are located in the city/metropolitan area. There are 94 "voluntary" teaching physicians involved in training our residents in addition to 80 full-time faculty members at our site. Obvsiously, recent rules of CMS has created a significant strain on our institution to achieve our mission. Regardless of how the agency decides to require organizations to count residents, an increased burden on teaching hospitals is inevitable:

- Because the base year for GME reimbursement is 22 years ago, institutions remain challenged to meet financial burdens for GME. Reimbursement to sponsoring institutions remains essesntially based on old methodology and is declinining in terms of today's costs.
- Due to resident limits/caps, institutions training the majority of residents are already at or over their present limits to experience reimbursement of all residents currently providing patient care servies to beneficiaries.
- Due to the proliferation of variables that now result in decreasing resident counts to FTE's, institutions cannot achieve full count of a resident---even as residents tend to work between 50-80 hour work weeks again providing services to beneficiaries.
- CMS has redefined the term "volunteer" beyond repair---no longer are physicians in certain practice settings allowed to volunteer---hospitals and physicians are no longer allowed to enter into their own private financial relationships.

Although, I believe the current proposed rule is an honest attempt to listen to the industry and demonstrates a willingness to understand the problems inherent to organizations, the current proposed regulation continues to make assumption or cause further confustion that can cause harm to programs. Nonetheless, the following comments are made for consideration regarding the proposed rule to take effect July 1, 2007.

1. *Flawed logic:* Although CMS has disallowed the counting of resident time in non-patient care activities, this rule presribes a basic level of funding for supervision required in these activities. It is ironic that CMS is requiring institutions to provide funding for supervision of these activities when the resident count is excluded.

2. *3- hour proxy:* The use of a proxy is well intended and appreciated as it alleviates the necessity for burdensome time studies. At our institution, residents are rotating to non-hospital sites for the sole purpose of patient care---not administrative or didactic activities. The three hour proxy does not fit our purposes and creating time studies remains a significant burden for a very minimal amount of non patient care assignment at these sites. For most of our sites, the amount of non patient care time translates to a few minutes for feedback or a written evaluation (15 minutes electronically submitted) at the end of the month assignment. This proxy also was determined by assuming that physician and resident assignments are based at the non-hospital site for an entire week. At our institution, residents are not placed in the NHS for an entire week, but only for a portion of the week which varies depending on assignment. They must come back into the hospital for various assignments and didactics. *I am proposing consideration of allowing an attestation by the supervising physician of the amount of time spent in non-patient care activities per week.*
3. *Use of clinic hours as denominator:* Additionally, this proxy is offset by calculation that requires use of the clinic hours to determine a proportion of time assigned in non-patient care at these sites. The assumption of the use of clinic hours assumes that regardless of the number of open clinic hours (20, 40, or 60), three hours would be the average non-patient care time. In reality, the number of open clinic hours is not relevant to the intent of its use in this instance. If we are focusing on teaching supervision, the improved denominator for the calculation would be the proportion of time the resident is assigned to the teaching physician. Physicians and residents are engaged in morning or evening rounds in the hospital—working to complete patient records--- beyond the time of clinic hours. *Proposed change: Allow the teaching physician to attest to an average hours worked and an average hours involved in non-patient care activity (as defined by providing services or discussing the care of individual patients).* ***If CMS chooses not to accept an attestation by the teaching physician on these variables, the three hour threshold should be reduced to .5 hours for every full day assigned to the site or a maximum of 2 hours per week.***
4. *Defining costs of residents:* The proposed rule presumes to define the phrase "all or substantially all" costs as costs that are associated with salaries, benefits and teaching supervision costs. There are many additional costs involved in sponsoring resident programs---including malpractice costs, accreditation fees, exam fees, signing bonuses, book allowances, PDA equipment, specialized/customized surgical tools/equipment---all of which are direct costs attributable and quantifiable to individual residents. Many other costs exist to support the program: program directors, coordinators, staff support, central GME staff, recruitment costs, graduation costs, IT support, HR support ..... these costs have been ignored in the proposed rule. At a minimum, CMS should recognize such major costs as malpractice which has increased significantly in recent years and remains the burden of teaching hospitals, particularly private, non-profit which bear this burden without public funds. These costs are actuarily determined annually by resident specialty and area easily quatifiable. Additionally other quantifiable costs include are other costs that are directly reported on resident 1099 forms as income-- such costs should not be ignored.
5. *Supervising Teaching Costs:* While non-patient care time of 3 hours per week has been estimated for an average week assignment, as stated above, residents may be assigned to the NHS only a portion of the week. Thus, teaching supervision estimates should be based on the portion of the week that is actually assigned to the site. For example, if only 20 hours per week is assigned to the site, the physician supervision cost should be rated at 50% of the prescribed 3 hour non-patient care assignment or 1.5 hours for the week for purposes of determining the 90% threshold.
6. *Lump Sum Payments to Major Teaching Partners:* The proposed rule does not recognize the

special arrangments of the major teaching partner. A major teaching hospital is defined as one that has over 100 residents and interns and sponsors multiple teaching programs. The major teaching partner is usually a medical school in which residents may see patients at the school's faculty practice plan offices to obtain required experiences. The hospital and teaching hospital already have an affiliation for all teaching (inpatient settings, didactics, administrative roles, etc.). Payments are generally made on a regular basis (we pay for the current month by the end of the month). These sites are located in close proximity/adjacent to the hospital teaching clinics/inpatient areas, literally often across the hall or on the next floor, it is very difficult to determine the time residents are actually spending at any site. Additionally residents may be supervised by physicians assigned by the medical school and may vary from day to day. Teaching supervision costs are reimbursed based on residents assigned and time involved of faculty and not generally specfic to this site. To decrease the burden of documentation when a large multi-specialty group is involved (such as the practice plan), I am proposing that hospitals and their affiliated medical schools with 100 residents or more be allowed to enter into a global agreement which would specify a proportion of costs to all NHS locations owned by the practice plan as defined by the parties to be representative of time assigned/rotations at these sites—eliminating the need to calculate costs based on each physician assigned to each site.

7. *Definition of volunteer physician---solo vs. group practice setting.* The proposed rule continues to assume that only physicians in solo practice settings are truly volunteering for teaching. There are many structures involved in physician practice settings. Although some group practices provide a predetermined compensation, the compensation is often based on expected productivity. Some practices require a reconcilation of income at the end of the year. Many of these practices do not have an administrator with authority to enter into an agreement on behalf of the group and physicians enter into their own agreement. The overall impact of how groups practice, unless they are subsidized by federal/state funds, is through patient care dollars. *Proposed: CMS should accept attestations by physicians as to the basis of their income. If their income is derived principally from patient care services and they attest that they are not bearing costs involved in teaching, CMS should accept the attestation and consider these physicians to be volunteers.*
8. *Use of Source Data:* I am very appreciative the fact that CMS has relaxed their position on the use of financial information of physicians eliminating the need to get actual information from the physician. I have little experience in working with various sources of information on physician compensation and am therefore uncertain as to how to respond to the proposed source AGMA. It is my understanding, however, that CMS has asked for input into the use of median or mean for the calculation of salary. It is also my understanding that there is an academic physician salary survey done by the AAMC which is done by region. This may also be a good source. Because this rule has an overall impact of reducing reimbursement or requiring new expense, I believe it would be beneficial to give hospitals a choice of approved sources and to allow them to utilize the most advantageous source and data point (mean or median) to meet their need.
9. *Special consideration of Free Health Clinics or FQHC's or rural sole provider--* Please give consideration to waiving these requirements to placement of residents in free health clinics where supervising physicians are volunteers or paid by federal or state grants or other subsidized/special reimbursed locations. Residents are often placed in these areas at the request of these organizations and not necessarily to meet an accreditation requirement. Payment of teaching supervision requirements could cause sponsoring institutions to withdraw resident support to these areas. *Proposed: CMS to waive requirements for payment of teaching supervision costs with organizations of this nature and who are engaged in supervision of residents only for the purposes of patient care. CMS should accept an agreement for volunteer*

teaching if this entity is willing to state that they are not incurring non-patient care administrative teaching costs of residents.

10. *Related Entities.* Please give consideration of reducing burden to major teaching institutions for teaching done at related entities. For example, the hospital owned physician practices are a related entity where some residents rotate. The hospital currently supports these practices with all infrastruture and all physician costs. To alleviate burden, and since the hospital is already providing all costs, please consider eliminating the need for a teaching agreement which requires calculation based on each physician specialty or requires calcuation for each site.
11. *Specialty for calculations.* When residents are rotating to a group practice where there are multi-specialities, calculation of the teaching supervision costs should be related only to the required rotation assignment as to *why* the resident is assigned. For example, a resident rotating to an orthopedic surgery practice where a radiologist is employed---in this example a radiologist is not principal to the teaching. The resident is assigned for orthopedics. The specialty of the teaching supervisor should relate only to the assignment of the resident (which is specified) in the agreement.
12. *Annual calculations*. Our resident program is a small program compared to many, To reduce the burden of documentation, consider allowing programs to enter into a multi-year agreement so as not to require new agreements or negotiations annually with non-hospital sites/physicians. Currently, the ACGME has proposed to require programs to renew all program agreements on a five year cycle.
    Proposed: CMS should allow institutions to engage in a multi-year agreement. At a minimum, consider a bi-annual agreement; at best, coinciding with the requirements of the accrediting bodies would be a huge benefit.

COMMENT ON BURDEN OF DOCUMENTATION.

While the proposed rule has intended to use proxy measures for many variables with sole intent to reduce burden (very appreciated)--- the burden of any of this is still great. There is undue burden in the documentation required to calculate physician variables and site variables required.

To manage 130 residents going to 107 non-hospital assignments to 94 independent non-faculty physicians is a challenge at best. The burden of maintaining the required documentation on the residents and faculty is an ongoing process that will change annually, although the assignments do not.

This latest requirement assumes that residents spend 3 hours a week in non patient care but ignores that residents might work 80 hours a week caring for patients and doing their work. The latest requirements assumes that physicians musts have a cost if they receive any predetermined compensation---even if they consider there is no cost.

To comply with these agreements, personnel resources will be required to manage letters of agreement and to renew them annually. Please give consideration to reducing the burden by the following suggestions as noted above:

- Allow a single time agreement with major affiliated partner (medical school)
- Do not require organizations to have agreements with themselves (sister organizations)
- Waive requirements for special locations
- Allow for multi-year agreements

All of these activities of late, have increased burden to an otherwise capped reimbursement audience. The fact is that residents work between 50-80 hours per week. The bulk of this IS patient care---and

for many programs it is to government beneficiaries and to indigent/charity care recipients. We are capped at a number of residents and all of these requirements tend to do nothing but reduce the counts of residents to at or below the cap. I am not sure why we go through all the documentation steps at the provider side---and the audit steps on the government side to do all of this when we are already capped in what we can receive. I propose that the resources spent on auditors, lawyers, appeals processes, as well as institutional financial specialists and accountants required to address and argue these requirements could be better spent in providing patient care services.

Sharon Hall
Designated Official for GME
Charleston Area Medical Center
Charleston, West Virginia

Submitter : Ms. Jill L. Force **Date:** 03/26/2007

Organization : LifeCare Hospitals

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-1529-P-130-Attach-1.PDF

#130

LIFECARE
HOSPITALS

March 26, 2007

By Electronic Mail

Leslie V. Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1529-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-1529-P; Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates and Policy Changes; Proposed Rule

Dear Acting Administrator Norwalk:

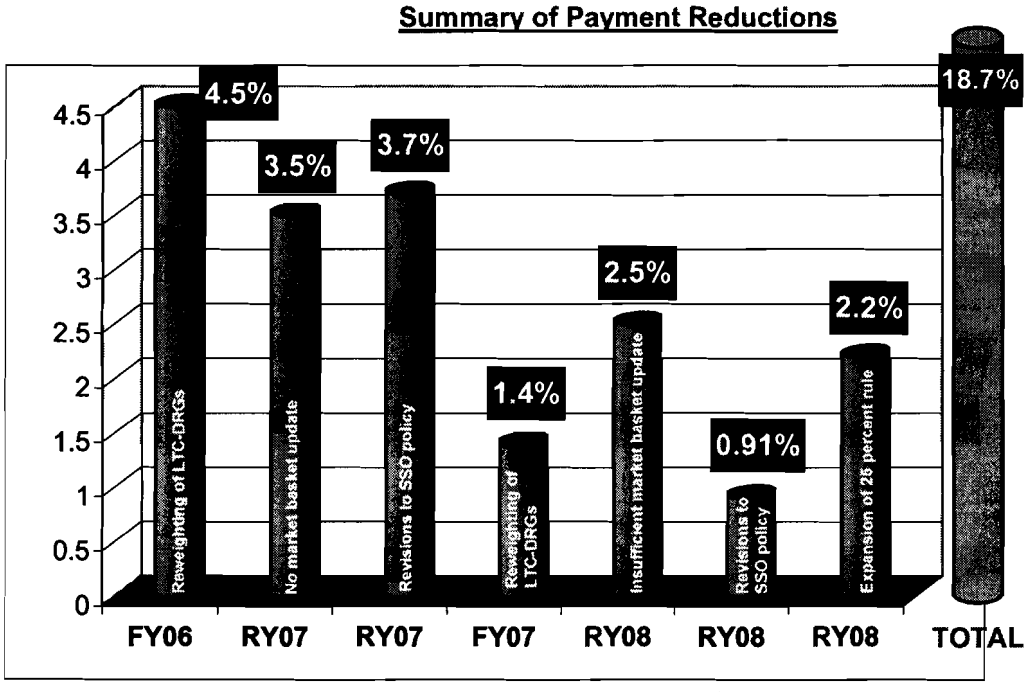
On behalf of LifeCare Holdings, Inc. ("LifeCare"), which owns and operates long-term acute care hospitals, I am writing to comment on the Centers for Medicare & Medicaid Services' proposed rule entitled "Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates and Policy Changes" (the "Proposed Rule").[1] We appreciate this opportunity to comment on the Proposed Rule and look forward to working with CMS to ensure that these provisions are implemented in a manner that reflects our concerns.

I. EXECUTIVE SUMMARY

The Proposed Rule presents flawed Medicare payment policies predicated on a number of fundamental misconceptions about the long-term care ("LTC") hospital industry. If finalized, the Rule would result in severe Medicare payment reductions for LTC hospitals. These reductions, which CMS estimates as having an aggregate impact on the LTC hospital industry of 2.9 percent, or $117 million, would exacerbate the effects of the already substantial cuts that LTC hospitals have experienced in recent years. Specifically, when added to the payment reductions experienced in 2005 and 2006, implementation of the Proposed Rule would mean that LTC hospitals would have

[1] 72 Fed. Reg. 4,776 (proposed Feb. 1, 2007).

seen their reimbursement decline by more than 18.7 percent over a three-year span, as demonstrated below:



That CMS is proposing to implement these cuts at this time is particularly mystifying because, as discussed more fully below, the payment reductions implemented in recent years have significantly reduced Medicare margins for LTC hospitals and appear to have substantially slowed the recent growth in these facilities.

For LifeCare in particular, we anticipate that implementation of the Proposed Rule would result in Medicare payment reductions of up to $24 million per year. Faced with such large losses, we may have no choice but to consider closing several of our hospitals. Thus, these payment reductions could prevent us from continuing to provide high-quality care to many of the medically complex beneficiaries who are treated at our hospitals.

We have a number of specific concerns about the Proposed Rule, which are summarized below:

A. Expansion of the 25 Percent Rule

1. To address its concerns over the appropriateness of LTC hospital admissions, CMS should implement patient and facility criteria rather than expand the 25 Percent Rule.

CMS proposes to remedy the perceived problem of Medicare making two payments for one episode of care by expanding the "25 Percent Rule," which currently limits LTC hospital hospitals

within hospitals ("HwHs") to the general inpatient prospective payment system ("IPPS") rate if more than 25 percent of admissions are referred from the host hospital, to all Medicare discharges from LTC hospitals and LTC hospital satellites admitted from non-co-located hospitals as well as grandfathered LTC HwHs and LTC hospital satellites. While this remedy would certainly reduce payments to LTC hospitals for certain admissions from general acute care hospitals, expansion of the 25 Percent Rule would not meaningfully address the fundamental issue that CMS says it is trying to resolve: inappropriate admissions to LTC hospitals from short-term acute care hospitals. Instead, it would impede legitimate access to highly specialized, necessary care. To address the issue of inappropriate admissions, CMS should implement patient and facility criteria for LTC hospitals, as both the Medicare Payment Advisory Commission ("MedPAC"), Congress's advisory body on Medicare matters, and the Research Triangle Institute ("RTI"), the independent entity that CMS commissioned to study this question, have recommended. Further, two bills recently introduced in the 110th Congress, the Medicare Long-Term Care Hospital Improvement Act of 2007 (S. 338 and H.R. 562), demonstrate strong Congressional support for the proposition that CMS should implement patient and facility criteria in lieu of making arbitrary payment reductions.

2. The proposed expansion of the 25 Percent Rule is arbitrary and unsupported by the evidence.

Although inappropriate LTC hospital admissions arising from certain business relationships between short term acute care hospitals and LTC hospitals would be a legitimate concern for CMS if they existed, CMS's solution to this perceived problem—expansion of the 25 Percent Rule—is not supported by any credible evidence. CMS is instead relying on "anecdotal" evidence of inappropriate relationships between short-term acute care hospitals and LTC hospitals and drawing an unsubstantiated connection between referrals from short-term care hospitals and purported arrangements to engage in patient shifting. Implementing an expanded 25 Percent Rule on the basis of anecdotal evidence and conjecture is wholly unsupported and legally suspect.

3. Expansion of the 25 Percent Rule would force LTC hospitals into an unsustainable financial position.

Although CMS claims that LTC hospitals may minimize the effect of the Proposed Rule by adjusting their admissions policies, the Medicare regulations restrict LTC hospitals from denying admission to Medicare beneficiaries. Under the regulations, a Medicare provider may not have different admissions criteria for Medicare patients than for all other patients. Therefore, expansion of the 25 Percent Rule would force LTC hospitals into the untenable financial position of having to admit high-cost patients without receiving adequate payment for the services they provide those patients.

4. In proposing an expansion of the 25 Percent Rule, CMS ignores fundamental principles of PPS.

The Proposed Rule would violate the principle that Medicare pays hospitals on the basis of the average costs of delivering care—the fundamental premise of PPS. Under the Proposed Rule, LTC hospitals would continue to accept the sicker, more medically complex patients that are typical for LTC hospitals but, after reaching the 25 percent threshold, would be unable to receive payments adequate to offset the costs of treating these severely ill individuals. Over time, payment would be shifted away from reimbursing for the average costs of care to a punitive payment system under

which LTC hospitals would be certain to incur financial losses for a large percentage of their patients.

5. The proposed expansion of the 25 Percent Rule to grandfathered HwHs violates Congressional intent and is not supported by the evidence.

In the Balanced Budget Act of 1997, Congress made clear its intent to protect grandfathered HwHs from application of the HwH rules. Throughout the implementation of the LTC hospital PPS and the adoption of the existing 25 Percent Rule, CMS has recognized the special status that Congress granted these hospitals, and has specifically acknowledged that the 25 Percent Rule does not apply to these facilities. For their part, grandfathered LTC hospitals have relied for years on these CMS statements. The Proposed Rule unfairly penalizes hospitals that relied on this historic treatment, and applying the 25 Percent Rule to grandfathered HwHs at this time may very well result in the closure of many of these facilities. As with the proposed expansion of the 25 Percent Rule to freestanding LTC hospitals, CMS offers no evidence in the Proposed Rule to support this abrupt departure from long-standing policy.

6. The proposed expansion of the 25 Percent Rule is premature.

The current 25 Percent Rule is designed to address many of the concerns regarding inappropriate LTC hospital admissions in the specific setting where CMS believes they are most likely to be generated. Therefore, before implementing an expansion of this policy, CMS should allow sufficient time to study and collect data on the impact of the existing Rule, which was phased in over a four-year period that ends in FY 2008. CMS itself acknowledges, in its discussion in the Proposed Rule of the one-time budget neutrality adjustment, that there is great value in evaluating the most current data available before making important payment policy decisions.

7. Existing CMS policies already address concerns about patient shifting.

Medicare regulations have already been implemented to discourage patient shifting, including the post acute care transfer policy. This policy was created because of the same concerns that CMS articulated in the Proposed Rule, i.e., that general acute care hospitals are discharging patients too early, resulting in two payments for one episode of care. Thus, the 25 Percent Rule should not be expanded because it is clearly duplicative of existing Medicare policies.

B. Expansion of the SSO Policy

As with the proposed expansion of the 25 Percent Rule, CMS's rationale for revising the short stay outlier ("SSO") payment methodology rests largely on unfounded assumptions that LTC hospitals are improperly admitting patients from general acute care hospitals, that payment based on an "IPPS comparable threshold" is an appropriate method for paying LTC hospitals, and that LTC hospitals are somehow able to predict a patient's length of stay. Here again, CMS does not provide any evidence to support these assumptions. Furthermore, as with the proposed expansion of the 25 Percent Rule, CMS's proposal is premature. Neither CMS nor LTC hospitals have had sufficient time to evaluate the effects of the current SSO payment methodology, which was implemented less than one year ago. At a minimum, CMS should allow all interested parties an opportunity to ascertain the impact of these recent changes before embarking upon yet another refinement of this

methodology. CMS should also propose specific regulatory language before it finalizes these changes.

C. Market Basket Update for RY 2008

The proposed 0.71 percent market basket update would result in reimbursement rates below the cost of care and CMS has not offered any evidence supporting its contention that a downward adjustment to the update is necessary to account for changes in coding practices. We therefore strongly recommend setting the market basket update for RY 2008 at the most recent market basket estimate for that year of 3.2 percent.

D. One-Time Budget Neutrality Adjustment

LifeCare believes that a one-time budget neutrality adjustment is unnecessary at this time, or at any future time. The purpose of the adjustment is to ensure 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 for future years."[2] CMS has made, and continues to propose, significant Medicare payment reductions to LTC hospitals and any "significant differences" between actual and estimated payments in the first year of the LTC hospital PPS surely would have been offset by this time. CMS should not make this adjustment in this rate year or any future rate year.

E. Budget-Neutral Reweighting of LTC-DRGs

LifeCare agrees that a budget neutrality requirement for reweighting of LTC-DRGs is appropriate because it is consistent with CMS's policy with respect to IPPS DRG reweighting. However, CMS should continue to monitor the annual reweighting of LTC-DRGs to ensure that it does not result in the redistribution of payments from high acuity DRGs to lower acuity DRGs, pending implementation of revised certification criteria designed to screen out inappropriate cases.

II. BACKGROUND

A. Company and Industry Background

LifeCare was founded in 1993. We currently operate 20 LTC hospitals, with 893 licensed beds in nine states. Two of these hospitals, located in Shreveport, Louisiana, are currently "grandfathered" from application of the 25 Percent Rule. Our facilities employ approximately 2,800 people in various clinical and support capacities.

LTC hospitals provide high levels of inpatient care for far longer periods than short-term acute care hospitals. Because of their high acuity patients, LTC hospitals often require more resources to provide patient care than do short-term care hospitals. As MedPAC stated in its March 2007 report, "LTCHs provide care to patients with clinically complex problems, such as multiple acute or chronic conditions, who need hospital-level care for relatively extended periods."[3]

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[2] *Id.* at 4,802.

[3] Medicare Payment Advisory Comm'n, *Report to the Congress: Medicare Payment Policy* 219 (2007) (hereinafter "MedPAC report").

Therefore, in developing or modifying payment rates for LTC hospitals, it is important to distinguish them from rehabilitation facilities, psychiatric facilities, and skilled nursing facilities. These other alternatives to short-term care hospitals treat patients with conditions that are less likely to be associated with the higher acuities experienced by LTC hospital patients.

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

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

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

Significantly, RTI has specifically recognized the unique and important role that LTC hospitals play in the U.S. health care system, nothing that "[t]he majority of LTCH admissions are medically complex and there is general consensus that these cases need the more intensive treatment programs provided by LTCHs."[4]

[4] Barbara Gage, Ph.D., et al., *Long-Term Care Hospital (LTCH) Payment System Monitoring and Evaluation* 131 (2006) [hereinafter "RTI Study"].

B. The History of LTC Hospital Medicare Payments

Congress and CMS have long recognized that LTC hospitals have unique characteristics that require special payment status under the Medicare Program.[5] LTC hospitals, like many providers, were formerly reimbursed on the basis of their reasonable costs, subject to the cost limits established under Section 223 of the Social Security Act Amendments of 1972.[6] In 1982, Congress passed the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"),[7] which required the Secretary "to develop, in consultation with the Senate Finance Committee and House Ways and Means Committee, [M]edicare prospective reimbursement proposals for hospitals, skilled nursing facilities and to the extent feasible other providers."[8]

Significantly, prior to the enactment of TEFRA, the House of Representatives initially approved legislation that instructed the Secretary to develop a prospective payment system for both short-stay and long-stay hospitals, stating that "the Secretary [is] to develop and to submit to Congress by December 31, 1982, a Medicare prospective payment plan for hospital inpatient services and extended care services designed to take effect October 1, 1983. . . ."[9] However, the House-Senate Conference rejected this language, thus clearly indicating that Congress recognized the special problems a prospective payment system presents for extended care hospital services. Subsequently, the Secretary's response to the TEFRA Congressional directive to develop prospective reimbursement proposals stated that "467 DRGs were not designed to account for these types of [extended care] treatment" and that applying them to LTC hospitals "would be inaccurate and unfair."[10] Based on these findings and pursuant to its statutory discretion, CMS exempted LTC hospitals from the Section 223 limits on reasonable costs, noting that "[d]ata from long-term care hospitals are not adequate to include them in a system of case-mix adjusted limits based primarily on records from general short-term acute care hospitals."[11]

This recognition of the unique nature of LTC hospitals was reinforced in 1983 when Congress mandated implementation of a prospective payment system for most hospitals but specifically exempted LTC hospitals.[12] In enacting this provision, Congress expressly noted that "[t]he DRG system was developed for short-term acute care general hospitals and, as currently constructed, does not adequately take into account special circumstances of diagnoses requiring

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

[6] Social Security Amendments of 1972, Pub. L. No. 92-603, § 223, 86 Stat. 1329 (1972).

[7] Tax Equity & Fiscal Responsibility of 1982, Pub. L. No. 97-248, § 101, 96 Stat. 331 (1982) (codified at 42 U.S.C. § 1320b-5).

[8] *Id.*

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

[10] 67 Fed. Reg. 55,954, 55,957 (Aug. 30, 2002) (*quoting* HHS Report: "Hospital Prospective Payment for Medicare" (1982)).

[11] 47 Fed. Reg. 43,296, 43,299 (Sept. 30, 1982).

[12] Social Security Amendments of 1983, Pub.L. No. 98-21, § 601(d)(1)(B)(iv), 96 Stat. 331 (codified as amended at 42 U.S.C. §1395f, 1395e) (excluding from PPS "a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days").

long stays."[13] Thus, it is clear that, for almost 25 years, Congress and CMS have recognized that IPPS is an inadequate payment methodology for LTC hospitals.

In the FY 1995 IPPS Final Rule, CMS first recognized LTC hospitals within hospitals, i.e., hospitals that occupy space in a building also used by another hospital, or in one or more separate buildings located on the same campus as buildings used by another hospital.[14] In this rulemaking, CMS noted that LTC hospital "units" are statutorily prohibited and that the agency was concerned LTC hospital HwHs were acting as units.[15] To address this concern, CMS established separateness and control criteria for LTC HwHs, which required that HwHs establish functional and organizational separateness from their host hospitals so as not to operate as "units."[16] These separateness criteria include, for example, requirements that LTC HwHs establish separate governing bodies, chief medical officers, executive officers, and medical staff from their host hospitals.[17] The principal objective of these criteria was to address the shifting of costly, long-stay patients from host hospitals to on-site LTC hospitals, resulting in two hospital stays which would result in a financial windfall for both providers.[18] LTC hospitals not meeting these criteria could not retain their exempt status. Significantly, at the time, CMS exempted from the separateness and control criteria for a hospital's first cost reporting period beginning on or after October 1, 1995 those hospitals that had been excluded from PPS for any cost reporting period beginning on or after October 1, 1993 but before October 1, 1995.[19] In the Balanced Budget Act ("BBA") of 1997, Congress enacted a statutory "grandfathering" of certain HwHs from application of the separateness and control criteria, providing that "a hospital that was classified by the Secretary on or before September 30, 1995, as an excluded long-term care hospital shall continue to be so classified notwithstanding that it is located in the same building as, or on the same campus as, another hospital."[20] This statutory enactment led to the promulgation of grandfathering provisions in the IPPS regulations.[21]

In the Balanced Budget Refinement Act of 1999 ("BBRA"),[22] Congress directed the Secretary to develop and implement a DRG-based PPS for LTC hospitals.[23] This mandate was revised by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000

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[13] H.R. Rep. No. 98-25, at 141 (1983). *See also* S. Rep. No. 98-23, at 54 (1983) ("The DRG classification system was developed for short-term acute care general hospitals and, as currently constructed, does not adequately take into account special circumstances of diagnoses requiring long stays and as used in the medicare program is inappropriate for certain classes of patients").

[14] 59 Fed. Reg. 45,330, at 45,389 (Sept. 1, 1994); 42 C.F.R. § 412.22(e).

[15] 59 Fed. Reg. at 45,389.

[16] *Id.* at 45,396-97; 42 C.F.R. § 412.22(e).

[17] *See* 42 C.F.R. § 412.22(e)(1)(i) - (v).

[18] *See* 72 Fed. Reg. at 4,809. Separateness and control criteria were later established for LTC satellites in the FY 2005 IPPS final rule.

[19] 59 Fed. Reg. 45,396-97.

[20] Balanced Budget Act of 1997, Pub. L. No. 105-33 at § 4417, 11 Stat. 251 (to be codified at 42 U.S.C. § 1395ww).

[21] 42 C.F.R. § 412.22(f); *see also* 62 Fed. Reg. 45,966 (Aug. 29, 1997).

[22] Balanced Budget Refinement Act of 1999, Pub. L. No. 106-113, 113 Stat. 1501A-331.

[23] *Id.* at § 123.

("BIPA"),[24] which required the Secretary to "examine the feasibility and the impact of basing payment under such a system on the use of existing (or refined) hospital diagnostic related groups ("DRGs") that have been modified to account for different resource use of long-term care hospital patients as well as the use of the most recently available hospital discharge data."[25] In addition, BIPA noted that, if the Secretary were unable to implement a PPS for such hospitals by October 1, 2002, she was to implement a PPS using the existing acute care hospital DRGs, "modified where feasible to account for resource use of long-term care hospital patients using the most recently available hospital discharge data for such services. . . ."[26] Thus, in directing the Secretary to modify the DRGs to reflect different resource usage levels among various provider types, Congress reiterated its historic finding that general acute care hospitals and LTC hospitals provide different levels of care, and that the payment methodologies for these facilities should reflect this reality.

The Final Rule implementing the LTC hospital PPS was promulgated on August 30, 2002.[27] In that Rule, CMS noted the policy underlying any PPS—that hospitals will incur costs in excess of payments for some patients and costs below payments for others, and that an efficiently operated facility should be able to deliver care at an overall cost that is at or below the reimbursement rate.[28] CMS also recognized the inappropriateness of directly applying a general acute care PPS to LTC hospitals, noting that "Congress excluded these hospitals from the acute care hospital inpatient prospective payment system because they typically treated cases that involved stays that were, on average, longer or more costly than would be predicted by the DRG system. . . . [T]hese hospitals could be systemically underpaid if the same DRG system were applied to them."[29]

In recent years, the LTC hospital PPS has undergone a number of changes which have subjected LTC hospitals to several significant Medicare payment reductions. One important change was the establishment of the current 25 Percent Rule in the FY 2005 IPPS final rule.[30] This Rule generally provided that, if an LTC HwH's or LTC hospital satellite's discharges that were admitted from its host hospital exceeded 25 percent of its total Medicare discharges for a cost reporting period, that LTC HwH or LTC hospital satellite would receive an adjusted payment equaling the lesser of the amount otherwise payable under the LTC hospital PPS or an amount equivalent to what Medicare would otherwise pay under the IPPS.[31] The introduction of the 25 Percent Rule was phased in over a four-year transition period ending in FY 2008. CMS also provided that LTC HwHs that were grandfathered from the application of the separateness and control criteria would not be subject to the 25 Percent Rule.[32]

In the past two years, a number of additional payment reductions have further reduced Medicare payments for LTC hospitals. In the IPPS Final Rule for FY 2006, CMS made substantial

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[24] Benefits Improvement and Protection Act of 2000, Pub. L. No. 106-554, 114 Stat. 2763A-496.

[25] *Id.* at § 307(b)(1).

[26] *Id.* at § 307(b)(2).

[27] 67 Fed. Reg. 55,954 (Aug. 30, 2002).

[28] *Id.* at 55,957.

[29] *Id.*

[30] 69 Fed. Reg. 48,916 (Aug. 11, 2004).

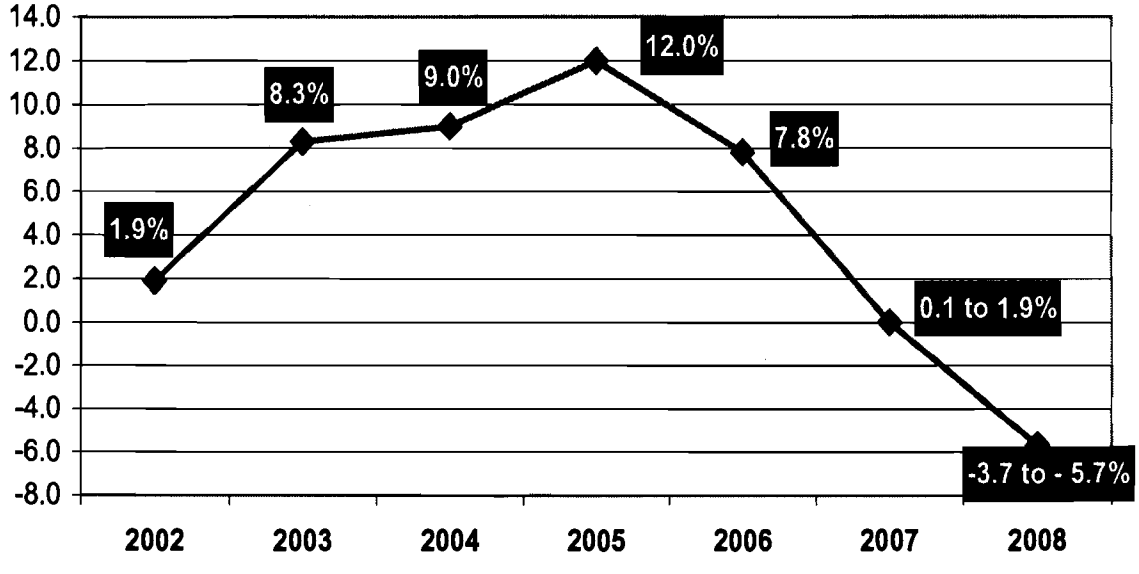
[31] *Id.* at 49,194; 42 C.F.R. § 412.534.

[32] 69 Fed. Reg. at 49,213; 42 C.F.R. § 412.534.

revisions to the weights for LTC-DRGs, resulting in an estimated 4.5 percent payment reduction.[33] In the LTC hospital PPS Final Rule for RY 2007, CMS adopted a zero percent market basket update, notwithstanding that LTC hospital costs increased by 3.6 percent in that year.[34] In this Final Rule, CMS also revised the payment methodology for short stay outliers by providing that LTC hospitals would be reimbursed for SSOs based on a blend of an amount comparable to the IPPS per diem payment amount and 120 percent of the LTC-DRG per diem payment amount.[35] This revision was expected to result in a 3.7 percent payment reduction for LTC hospitals in RY 2007.[36] In the IPPS Final Rule for FY 2007, CMS again reduced LTC hospital payments by reweighting the LTC-DRGs, which amounted to a 1.4 percent reimbursement cut.[37] Thus, the cumulative impact of these cuts over this two-year period was approximately 13.2 percent.

As a result of these payment reductions, LTC hospitals' Medicare margins have also dramatically declined. MedPAC reports that, while the LTC hospital Medicare margin in 2005 was approximately 12 percent, the margin for 2007 was estimated to be between 0.1 percent and 1.9 percent.[38] Significantly, MedPAC issued this estimate *before* promulgation of the Proposed Rule. When the proposed reductions are included in the margin analysis, we estimate that LTC hospital margins for 2008 would plummet to a *negative* 3.7 to 5.7 percent. These changes, summarized below, are unprecedented and ultimately unsustainable.

LTC Hospital Medicare Margins



[33] *See* 70 Fed. Reg. 47,277 (Aug. 12, 2005).

[34] 71 Fed. Reg. 27,798, 27,817 (May 12, 2006).

[35] 42 C.F.R. § 412.529.

[36] 71 Fed. Reg. at 27,803.

[37] 71 Fed. Reg. 47,870, at 47,971-47,994 (Aug. 18, 2006).

[38] MedPAC report, *supra* note 3, at 220.

As a result of these reduced payments and margins, the LTC hospital industry has also experienced a sharp slowdown in growth. In 2006, there was a net reduction in the number of LTC hospitals -- nine hospitals left the Medicare system, and only eight new hospitals were certified.

III. THE PROPOSED RULE

In this Proposed Rule, CMS is proposing a number of Medicare payment changes that, if finalized, could have a further devastating impact on LifeCare hospitals, the LTC hospital industry as a whole, and the patients we serve. Most significantly, CMS is proposing to:

- Extend the 25 Percent Rule to non-co-located hospitals, thereby extending the 25 Percent Rule to all "subclause (I)"[39] LTC hospitals;
- Extend the 25 Percent Rule to "grandfathered" HwHs and LTC hospital satellites;
- Reduce payments to the IPPS rate for SSO cases where the covered length of stay ("LOS") is less than or equal to the "IPPS comparable threshold"—defined as the average length of stay plus one standard deviation for the same DRG at short-term acute care hospitals; and
- Implement a market basket update of 0.71 percent.

The Proposed Rule also proposes to delay consideration of a one-time budget neutrality adjustment for the LTC hospital PPS and imposes a budget neutrality requirement for the annual reweighting of LTC-DRGs.

As described above, LTC hospitals provide services to patients who are demonstrably sicker, have higher acuities, and have more comorbidities than patients in the typical short-term acute care hospital. If implemented in its current form, the Proposed Rule would threaten these patients' ability to obtain high levels of care in the most appropriate setting. LifeCare anticipates that implementation of the Proposed Rule would result in Medicare payment reductions for its hospitals of up to $24 million per year. A significant portion of these reductions would result from the proposed expansion of the 25 Percent Rule to grandfathered HwHs. We are very concerned that, if the Rule is finalized as proposed, LifeCare may have to seriously consider closing several of our facilities. Presumably, many other similarly situated LTC hospital providers would also face these difficult choices. Thus, if implemented, the Proposed Rule could call into question the long-term financial viability of the LTC hospital industry and prevent many LTC hospitals from continuing to provide high-quality care to a particularly vulnerable class of Medicare beneficiaries.

[39] "Subclause (I)" LTC hospitals are defined as a "hospital which has an average inpatient length of stay ... of greater than 25 days...." 42 U.S.C. § 1395ww(d)(1)(B)(iv)(I). A "subclause II" hospital is one that has an average inpatient length of stay of greater than 20 days and has 80 percent or more of its annual Medicare inpatient discharges with a principal diagnosis that reflects a finding of neoplastic disease. 42 U.S.C. § 1395ww(d)(1)(B)(iv)(II).

IV. DISCUSSION

A. Comment: "Other Proposed Policy Changes for the 2008 LTCH PPS Rate Year"

1. The 25 Percent Rule

a. *To address its concerns over the appropriateness of LTC hospital admissions, CMS should implement patient and facility criteria rather than expand the 25 Percent Rule.*

The expansion of the 25 Percent Rule described in the Proposed Rule is largely predicated on CMS's belief that acute care hospitals "prematurely discharge Medicare patients to LTC hospitals for additional treatment during the same episode of care," thereby "generating two payments under two different payment systems for what was essentially one episode of beneficiary care."[40] CMS's proposed remedy for this perceived problem is to expand the 25 Percent Rule to grandfathered LTC hospital HwHs and LTC hospital satellites and to all Medicare discharges from subclause (I) LTC hospitals and LTC hospital satellites admitted from non-co-located hospitals.[41] However, this remedy fails to directly address the issue of inappropriate LTC hospital admissions. Instead, it would result in arbitrary payment reductions that lack any direct link to the level or quality of services provided by LTC hospitals and, as described above, would jeopardize the financial viability of the LTC hospital industry and impede patient access to LTC hospital services.

Rather than arbitrarily cutting payments and placing patients at risk, if CMS's goal is to ensure that patients are properly admitted to LTC hospitals, it should adopt a criteria-based system that would only permit the admission of patients who are medically complex and in need of the services provided by these facilities. MedPAC and its predecessor, the Prospective Payment Assessment Commission (ProPAC), have been on the record for nearly a decade recommending that the Secretary address this issue by defining LTC hospital eligibility and patient admissions criteria so as to ensure appropriate admissions.[42] For example, in its June 2004 report, MedPAC recommended that the certification criteria for LTC hospitals be strengthened to ensure that Medicare payments are made only to those providers that are administering medically complex care to severely ill patients.[43] MedPAC staff has observed that it should take CMS less than a year's time to develop such criteria.[44] Of note, MedPAC has also commented that the 25 Percent Rule does not ensure that patients will be treated in the most appropriate post-acute care setting.[45] For its part, CMS has expressed agreement with the concept of implementing patient and facility criteria

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[40] 72 Fed. Reg. at 4,812.

[41] *Id.* at 4,813.

[42] *See, e.g.*, 62 Fed. Reg. 29,902, 29,928 (Jun. 2, 1997) ("ProPAC has recommended that [CMS] ... evaluate whether the current Medicare certification rules that apply to these facilities should be changed...."); Medicare Payment Advisory Comm'n, *Report to the Congress, New Approaches in Medicare* 130 (2004) (hereinafter "2004 MedPAC report") ("The Congress and the Secretary should define long-term care hospitals by facility and patient criteria that ensure that patients admitted to these facilities are medically complex and have a good chance of improvement").

[43] 2004 MedPAC report, *supra* note 42, at 120.

[44] *See* Transcript, MedPAC Public Meeting, "Assessment of Payment Adequacy: Long Term Care Hospitals" at 264, 267 (Jan. 9, 2007).

[45] Letter from MedPAC to Dr. Mark McClellan, Adm'r, CMS, at 10 (July 9, 2004).

for years, but, for reasons that are difficult to fathom, has been unable to follow through on these recommendations.[46]

As you are aware, in response to the June 2004 MedPAC report, CMS contracted with RTI to examine the feasibility of implementing MedPAC's recommendations.[47] This report, published in January 2007, made recommendations on the establishment of patient and facility criteria that were nearly identical to MedPAC's.[48]

Consistent with the MedPAC and RTI recommendations, LifeCare urges the development of patient and facility criteria that, among other things: (1) measure patient characteristics to ensure that only medically complex patients are admitted to LTC hospitals; (2) ensure that LTC hospitals are capable of supporting the care of these high acuity patients; and (3) condition LTC hospital stays on appropriate patient medical complexity. Establishing such criteria would help reduce the number of admissions CMS perceives to be "inappropriate" without jeopardizing patient access to the appropriate level of care provided by LTC hospitals.

Recent actions by Members of Congress also demonstrate strong bipartisan Congressional support for establishing patient and facility criteria, rather than payment reductions, as the more effective method for ensuring appropriate LTC hospital admissions. At the end of the 109th Congress, Congressmen Phil English (R-PA) and Earl Pomeroy (D-ND) introduced legislation that would, among other things, define LTC hospitals with reference to specific facility criteria and establish patient criteria to ensure that LTC hospitals serve medically complex patients.[49] The legislation also contained an express prohibition on expansion of the 25 Percent Rule to freestanding LTC hospitals. Further, in April of last year, members of both the House and Senate sent letters to the CMS Administrator and the Secretary, respectively, urging CMS to establish LTC hospital patient and facility criteria.[50] The LTC hospital legislation was re-introduced by Congressmen English and Pomeroy in the 110th Congress (H.R. 562), and Senators Kent Conrad (D-ND) and Orrin Hatch R-UT) have introduced similar legislation in the Senate (S. 338).[51] According to estimates by the Acute Long Term Hospital Association, this legislation would reduce Medicare spending on LTC hospitals by approximately $1-2 billion over five years.

Finally, in the Final Rule implementing the 25 Percent Rule for co-located LTC HwHs, CMS stated that "[p]rior to the end of the 4 year transition period, [it] will reevaluate the HwHs criteria to assess the feasibility of developing facility and clinical criteria for determining the appropriate facilities and patients to be paid for under the Medicare LTCH PPS. If, during that time period, data

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[46] *See, e.g.*, 69 Fed. Reg. at 49,213 ("We agree with commenters that it may be worthwhile to examine patient and facility issues. Further examining of these issues may be beneficial in establishing the most effective and cost-efficient utilization of LTCHs and in assuring that Medicare beneficiaries receive the appropriate level of treatment and care in that setting.").

[47] 71 Fed. Reg. at 4,818.

[48] RTI Study, *supra* note 4.

[49] *See* Medicare Long-Term Care Hospital Improvement Act of 2006, H.R. 6236, 109th Cong. (2006).

[50] Letter from U.S. Senators to Dr. Mark McClellan, Adm'r, CMS (Apr. 11, 2006); Letter from Members of U.S. House of Representatives to Mike Leavitt, Sec'y, U.S. Dept. of Health & Human Servs. (Apr. 3, 2006). We understand that similar letters are being prepared in the 110th Congress.

[51] *See* Medicare Long-Term Care Hospital Improvement Act of 2007, H.R. 562, 110th Cong. (2007); Medicare Long-Term Care Hospital Improvement Act of 2007, S. 338, 110th Cong. (2007).

from well-designed studies (or other compelling clinical evidence) indicate that developing this criteria is *feasible, we would consider revisions to the HwH regulations.*"[52] With the four-year transition period set to expire next year, CMS has clearly failed to assess the feasibility of developing patient and facility criteria, notwithstanding that the agency has received data from well-designed studies, in fact, studies that CMS itself commissioned (i.e., RTI), demonstrating that developing criteria is feasible. CMS has reneged even on its own commitment to seriously examine the possibility of establishing patient and facility criteria.

In sum, in light of MedPAC's and RTI's recommendations and the emerging Congressional support for this proposition, we urge CMS to turn its attention to developing patient and facility criteria rather than expanding the 25 Percent Rule. Rather than expanding an arbitrary threshold[53] that has, at best, a tenuous connection with the problem CMS has identified, Medicare beneficiaries would be better served by implementation of patient and facility criteria that bear a clear relationship to the appropriateness of LTC hospital admissions.

b. *The proposed expansion of the 25 Percent Rule is arbitrary and unsupported by the evidence.*

As described above, the existing 25 Percent Rule was promulgated to reduce the number of inappropriate admissions to co-located LTC hospitals (i.e., medically unnecessary referrals from a host hospital to an LTC HwH to maximize Medicare reimbursement). Now, in the final year of the 25 Percent Rule's four-year phase-in, CMS is again seeking to remedy its concern that the Medicare program is, in the LTC hospital context, effectively making two payments for the same episode of care. However, the Proposed Rule does not provide any credible support for this assertion. CMS offers only vague assertions in support of its proposed extension of the 25 Percent Rule, such as being "aware anecdotally of the existence of 'arrangements' between Medicare acute and post-acute hospital-level providers that may not have any ties of ownership or governance relating to patient shifting that appear to be based on mutual financial gain rather than on significant medical benefits for the patient."[54] Such amorphous "anecdotal" evidence does not provide the meaningful opportunity for independent verification and comment by interested stakeholders that is required by the Administrative Procedure Act.[55] To fulfill this requirement, not only is an opportunity to comment required but also the opportunity to review the reasoning and data underlying a proposed rule.[56] While CMS does cite MedPAR data on LTC hospital admissions generally, the agency has not offered any concrete evidence of the existence of "arrangements" between non-co-located general acute care hospitals and LTC hospitals to manipulate the Medicare payment system. Thus, CMS has not fulfilled the APA requirement that interested parties receive a meaningful opportunity

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[52] 69 Fed. Reg. at 49,211-12 (emphasis added).

[53] The 25 percent threshold has no clinical basis. It was first suggested by a commenter to CMS's FY 1995 Proposed Rule that originally implemented the separateness criteria for HwHs. 59 Fed. Reg. at 45,390.

[54] 72 Fed. Reg. at 4,811.

[55] *See* 5 U.S.C.§ 553(c) (2006).

[56] *See, e.g., Home Box Office, Inc. v. FCC*, 567 F.2d 9, 35 (D.C. Cir. 1977) ("the notice required by the APA, or information subsequently supplied to the public, must disclose in detail the thinking that has animated the form of a proposed rule and the data upon which that rule is based"); *Portland Cement Association v. Ruckelshaus*, 486 F.2d 375, 394 (D.C. Cir. 1973) ("In order that rule-making proceedings ... be conducted in orderly fashion, information should generally be disclosed as to the basis of a proposed rule at the time of issuance").

to participate in the rulemaking process. The APA requires agencies to "develop an evidentiary basis for its findings . . . [and] examine the relevant data and articulate a satisfactory explanation for its action, including a 'rational connection between the *facts found* and the choice made.'"[57] Here, the agency has not found any facts and is basing significant policy changes that will affect millions of Medicare beneficiaries on mere "anecdotal" evidence. "Conclusory statements ... do not fulfill the agency's obligations."[58]

In the Proposed Rule, CMS cites MedPAR data indicating that "for over 50 percent of all freestanding LTC hospitals, at least 50 percent of their discharges were for patients admitted from an individual acute care hospital."[59] This data alone does not support CMS's conclusion that Medicare is paying twice for a single episode of care. Further, CMS does not reference data reflecting referral patterns for other provider types, whether acute care or post-acute care, to provide context as to whether this ratio is at, above, or below the average within the hospital industry. CMS also fails to establish a connection between these referral patterns and the existence of "arrangements" to engage in inappropriate patient shifting.

If Medicare was truly paying twice for the same episode of care, then the patients being discharged from the short-term acute care hospital and LTC hospital would be assigned the same DRG. MedPAR data, however, shows otherwise. There is very little overlap between the most common DRGs assigned to short-term and LTC hospital patients. LTC hospital patients experience different episodes of care in the short-term care hospital than in the LTC hospital, based upon different patient characteristics and courses of treatment. For example, the most common DRGs for patients discharged from a short-term care hospital to a LTC hospital are 541 and 542 (i.e., patients who have received tracheotomies and are also ventilator dependent). In 2005, there were 13,753 discharges from general acute care hospitals to LTC hospitals in these DRGs. However, only 1,212 patients were discharged from LTC hospitals with these DRG assignments. This demonstrates that patients are experiencing different episodes of care in the general acute care hospital and LTC hospital – thus, they are assigned different DRGs, reflective of a specific and different course of treatment provided in the LTC hospital.

MedPAR data from 2005 also show that the average LOS for general acute care hospital patients who are discharged to an LTC hospital is more than four days longer than the geometric mean LOS for *all* patients in the same DRGs.[60] This indicates that more medically complex patients typically sent to LTC hospitals are staying in the short-term acute care hospitals *longer* than the average patient. Thus, this data completely undermine CMS's contention that short-term acute care hospitals are systematically discharging patients to LTC hospitals in order to maximize their profits.

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[57] *Motor Vehicle Mfrs. Ass'n v. State Farm Mutual Automobile Ins. Co.*, 463 U.S. 29, 43 (June 24, 1983) (quoting *Burlington Truck Lines v. United States*, 371 U.S. 156, 168 (1962)) (emphasis added); *In re Sang-sue Lee*, 277 F.3d 1338, 1344 (Jan. 18, 2002).

[58] *In re Sang-su Lee*, 277 F. 3d at 1344.

[59] 72 Fed. Reg. at 4,812.

[60] The only exception to this pattern occurs with respect to DRGs 541 and 542 (i.e., patients dependent on a ventilator who also received a tracheotomy). Payment for nearly 70 percent of these patients is less than a full DRG amount because payment is adjusted by the post acute care transfer policy. *See* the discussion of the post acute care transfer policy below.

CMS also states in the Proposed Rule that "[it has] become aware of certain LTCH companies that have both established new LTCHs and/or are considering relocating existing HwHs or LTCH satellites so that they are at least 300 yards from the acute care hospital, thus side-stepping the intent of existing § 412.534."[61] However, the mere fact that new LTC hospitals may be located 300 yards from an acute care hospital does not imply that the two facilities are "gaming" the LTC hospital PPS. Here again, CMS cites no evidence of such "gaming" other than the bald assertion that these arrangements are suspect.

CMS relies in the Proposed Rule on a 2005 Lewin Group report commissioned by the National Association of Long Term Care Hospitals (NALTH) concerning patients admitted to LTC hospitals from a single source.[62] NALTH has emphasized, however, with respect to CMS's reliance on the report, that the report stated that the 25 Percent Rule is at "extreme variance with the demographics of how patients are referred to post-acute hospitals throughout the United States."[63] NALTH has requested that CMS correct the public record by fully reporting the Lewin Group's conclusion, including that the application of the 25 Percent Rule is an arbitrary threshold and ignores how post-acute care referrals in the hospital industry have evolved.[64] Further, CMS has not analyzed the underlying data that the Lewin Group used and has not made the report available to stakeholders to review its conclusions or analyze its methodologies. We urge CMS to make the full report available and perform a detailed analysis of its findings.

LifeCare recognizes CMS's concern regarding the potential for inappropriate LTC hospital admissions in certain business relationships between general acute care hospitals and LTC hospitals. As described above, we believe—and MedPAC and RTI agree—that adopting admissions criteria that are clinically based and do not rely solely on arbitrary admissions thresholds would be a far more effective method to curtail any such abuses.

c. *Expansion of the 25 Percent Rule would force LTC hospitals into an unsustainable financial position.*

Not only does the proposed expansion of the 25 Percent Rule fail to directly address the appropriateness of LTC hospital admissions, it would also force LTC hospitals into accepting payment terms that threaten their financial stability. CMS states that it is "unable to determine how significant the impact of some of the provisions of this proposed rule may be on small entities since [it] expect[s] many LTCHs to adjust their admission practices if some of these provisions are implemented."[65] Similarly, in its March 2007 report, MedPAC stated in discussing the impact of the current 25 Percent Rule that "[i]f HwHs do not change their behavior, the Medicare margin [for LTC hospitals] is estimated to be 0.1 percent. If they change behavior to avoid payment reductions, the margin is estimated to be 1.9 percent. There are a number of ways HwHs can change behavior to minimize the effect of the rule."[66] On their face, these statements demonstrate that CMS and

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[61] 72 Fed. Reg. at 4,812.

[62] *Id.* at 4,818.

[63] Letter from NALTH to Dr. Mark McClellan, Adm'r, CMS, at 24 (Mar. 13, 2006).

[64] *Id.* at 25.

[65] 72 Fed. Reg. at 4,832.

[66] MedPAC report, *supra* note 3, at 221.

MedPAC expect LTC hospitals to alter their admissions policies to minimize the impact of payment policy changes.

However, LTC hospitals, and, indeed, all Medicare-participating providers, do not have unbridled discretion to deny admission to Medicare beneficiaries or have separate admissions policies specific to Medicare beneficiaries. Specifically, the Medicare regulations state that CMS may terminate a provider's Medicare participation agreement where the provider "places restrictions on the persons it will accept for treatment and it fails either to exempt Medicare beneficiaries from those restrictions or to apply them to Medicare beneficiaries the same as to all other persons seeking care."[67] Thus, a Medicare provider may not refuse admission to Medicare patients unless the provider also refuses admission to similarly situated non-Medicare patients. CMS has confirmed this restriction in various pronouncements and rulings.[68] LTC hospitals, therefore, cannot refuse to admit Medicare patients on the basis of payment inadequacy. At the same time, if the 25 Percent Rule is expanded as proposed, LTC hospitals must accept the lower Medicare payments levels that apply after the LTC hospital reaches the 25 percent threshold for admissions from any general acute care hospital. As such, CMS effectively is incenting LTC hospitals to make admissions decisions based on considerations other than medical appropriateness.

CMS is placing LTC hospitals in the untenable position of having to accept sicker, more medically complex Medicare patients but, after admissions exceed the 25 percent threshold, being unable to receive payments sufficient to offset the high costs of treating these severely ill patients. Thus, the proposed expansion of the 25 Percent Rule would threaten the financial viability of these hospitals and their ability to continue providing Medicare beneficiaries with the specialized care they require.

d. *The proposed expansion of the 25 Percent Rule ignores fundamental principles of PPS.*

The basic premise of a prospective payment system recognizes that Medicare pays hospitals in "an amount per discharge based on the *average* costs of delivering care for that diagnosis...."[69] The Proposed Rule would violate this premise by removing a significant number of cases from the standard LTC hospital PPS formula and reimbursing them at a level appropriate only for general acute care hospitals. In so doing, CMS's proposal would also contravene its historical pronouncements regarding LTC hospital PPS payments as well as Congress's basis for first excluding LTC hospitals from PPS and then establishing a separate PPS—that the general IPPS rates are inadequate to reimburse LTC hospitals for the care they provide.

Specifically, as described above, Congress in 1983 acknowledged that the "DRG system was developed for short-term acute care general hospitals and as currently constructed does not

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[67] 42 C.F.R. § 489.53(a)(2).

[68] *See, e.g.,* 58 Fed. Reg. 46,270 (Sept. 1, 1993) ("[A] hospital may not refuse to provide a covered service to a Medicare beneficiary if it provides that service to other patients"); 60 Fed. Reg. 45,778, 45,789 (Sept. 1, 1995); 59 Fed. Reg. 45,330, 45,343 (Sept. 1, 1994); *see also* Termination Of Provider's Agreement -- Withholding A Segment Of Services From Title XVIII Medicare Patients, HCFA Ruling No. 78-19 ("[n]o Medicare patient may have withheld from him services ordinarily provided by the health care institution to its patients generally if the institution is to qualify or remain qualified as a provider of services").

[69] 71 Fed. Reg. 4,647, at 4,693 (Jan. 27, 2006) (emphasis added).

adequately take into account special circumstances of diagnoses requiring long stays."[70] Congress reiterated this concern about the "special circumstances" of LTC hospitals when it directed CMS to develop an LTC hospital-specific PPS in the BBRA and BIPA, and CMS itself expressly recognized in the Final Rule implementing the LTC hospital PPS that these hospitals "would be systemically underpaid if the [IPPS] DRG system were applied to them."[71] Yet, CMS is proposing a policy change that is clearly at odds with this historic treatment of LTC hospitals within the Medicare Program and the clear Congressional mandate to afford LTC hospitals protected status.

Thus, although LTC hospitals accept more medically complex and costly patients, once a facility reaches the 25 percent threshold for any referring acute care hospital, it will be unable to receive the appropriately higher payments that are necessary to provide equitable reimbursement. Over time, these payment shortfalls will move LTC hospitals further and further away from the PPS goal of providing payment based on the average costs of providing care and contravene the Congressional directive to provide payment to LTC hospitals that recognize the "special circumstances" of these institutions.

e. *The proposed expansion of the 25 Percent Rule to "grandfathered" HwHs violates Congressional intent and is not supported by the evidence.*

As with CMS's proposed expansion of the 25 Percent Rule to all subclause (I) LTC hospitals, CMS has offered no evidence to support an expansion of the 25 Percent Rule to grandfathered HwHs. CMS states that it does not "believe that it is reasonable to assume that by creating a limited exception for these hospitals, Congress was immunizing these facilities from any further regulation by the Secretary as to their growth and financial impact on the Medicare program."[72] We disagree with CMS that Congress did not intend to create a protected class of provider. As described above, in enacting Section 4417 of the BBA, Congress gave this small group of HwHs special status in the Medicare payment system by excepting them from application of the separateness and control criteria, and CMS at the time promulgated regulations that implemented this Congressional directive. In the BBA conference report, Congress stated that the reason for the statutory changes was because "[c]ertain hospitals that have provided quality care to Medicare beneficiaries are in jeopardy because of ... [CMS] regulations which would make them no longer eligible to qualify as long-term care hospitals. This [legislative] provision would ensure that they would continue to qualify as [an LTC hospital] as long as they maintained an average length of stay of 25 days and other Medicare certification requirements."[73] Later, when CMS promulgated the 25 Percent Rule, it exempted these grandfathered HwHs from application of the Rule by determining that the Rule applied only to hospitals meeting the separateness and control criteria.[74] The agency did so in full recognition of these hospitals' special Congressionally conferred status and historic treatment.

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[70] H.R. Rep. No. 98025, at 141 (1983).

[71] 67 Fed. Reg. at 55,957.

[72] 72 Fed. Reg. at 4,813-14.

[73] H.R. Rep. No. 105-149, at 1339 (1997) (Conf. Rep.).

[74] 42 C.F.R. § 412.534(a).

Since 1994, CMS has repeatedly maintained that the HwH rules do not apply to grandfathered LTC hospital HwHs. Significantly, in the Final Rule for the FY 2003 IPPS update, CMS stated that:

> The intent of the grandfathering provision was to ensure that hospitals that had been in existence prior to the effective date of our hospital-within-hospital requirements *should not be adversely affected by those requirements*. To the extent hospitals were already operating as hospitals-within-hospitals without meeting those requirements, we believe it is appropriate to limit the grandfathering provision to those hospitals that continue to operate in the same manner as they had operated prior to the effective date of those rules.[75]

CMS has also stated that "in establishing grandfathering provisions, our general intent has been to protect existing hospitals from the potentially adverse impact of recent, more specific regulations that [the agency] now believe[s] to be essential...."[76] Thus, CMS itself has affirmed the principle that grandfathered hospitals should not be subject to the HwH rules (including the 25 Percent Rule) and that the purpose of grandfathered status is to protect certain HwHs from any new requirements that would result in an "adverse impact" on these hospitals.

Significantly, CMS has not provided a rational basis for altering the protected status of these LTC providers. It is noteworthy that the agency's rationale for the original 25 Percent Rule -- concern about the growth in the number of LTC hospitals in recent years -- has no applicability to grandfathered LTC HwHs, which, by definition, cannot grow in number.

In sum, throughout the implementation of the LTC hospital PPS and the adoption of the current 25 Percent Rule, CMS has expressly recognized the special status that Congress granted grandfathered LTC hospitals, and grandfathered LTC hospitals have long relied on CMS's statements that the HwH rules, including the 25 Percent Rule, do not apply to them. Applying the 25 Percent Rule to grandfathered HwHs at this time would upset the well-settled expectations of these facilities, threaten their financial viability, and violate Congressional intent.

f. *The proposed expansion of the 25 Percent Rule is premature.*

In proposing to expand the 25 Percent Rule, CMS is acting without allowing sufficient time to study and collect data on the impact of the existing 25 Percent Rule. In particular, the current 25 Percent Rule is designed to address many of the concerns regarding inappropriate LTC hospital admissions in the specific setting where CMS believes they are prone to be generated. As noted above, this change, initiated in FY 2005, was to be phased in over four years.[77] Because the existing 25 Percent Rule has not been fully implemented, CMS does not yet have sufficient data to evaluate whether the Rule is already achieving CMS's policy goals.

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[75] 68 Fed. Reg. 45,346, 45,463 (Aug. 1, 2003) (emphasis added).

[76] *Id.*

[77] 69 Fed. Reg. at 49,251-52.

In fact, CMS, in its discussion in the Proposed Rule of the one-time budget neutrality adjustment, has acknowledged the value of gathering sufficient data to conduct a thorough evaluation before making important policy decisions. In discussing its decision to delay making this adjustment, CMS states that "we believe that postponing the deadline... would result in the availability of additional data... and, therefore, our decisions regarding a possible adjustment would be based on more complete and up-to-date data."[78] This statement acknowledging the need to gather and evaluate sufficient data before making a decision on the one-time budget neutrality adjustment is wholly inconsistent with CMS's proposal to implement a much more radical change—expansion of the 25 Percent Rule—before there is time to evaluate the effects of the fully implemented existing Rule. At a minimum, therefore, the agency should delay implementing the proposed expansion of the 25 Percent Rule until credible, statistically valid data is available to evaluate the impact of the current Rule.

Further, in the Proposed Rule, CMS states that it is still reviewing some of the RTI recommendations, including the feasibility of developing patient and facility level criteria.[79] CMS has also noted that RTI has formed a "technical expert panel" to further develop some of its recommendations. Thus, based on CMS's own admission, it should not make significant policy changes such as those proposed here until the agency has had a full opportunity to review and process all of the RTI recommendations.

Finally, CMS should postpone any additional significant policy changes until the effects of full implementation of the LTC hospital PPS are well understood. As the agency is aware, the LTC hospital PPS was implemented over a five-year period. LTC hospitals are in the first year of full LTC hospital PPS implementation. CMS has already made significant policy and payment changes to the LTC payment system during this phase-in period. The agency should hold off from implementing additional changes at this time that would inject further instability into the LTC hospital PPS.

g. *Existing CMS policies already address concerns about patient shifting.*

Medicare regulations have already been implemented to discourage inappropriate patient shifting between providers. For example, under the post acute care transfer policy, general acute care hospitals are reimbursed below the full DRG payment when a patient's length of stay is shorter than the geometric mean length of stay for the DRG whenever patients in selected DRGs are discharged to other providers, including LTC hospitals. Significantly, 85 percent of DRGs applicable to short-term acute care hospital discharges to LTC hospitals are subject to this policy. The post acute care transfer policy was created because of the same concerns CMS has articulated in the Proposed Rule, i.e., that the general acute care hospital is discharging patients too early, resulting in two payments for one episode of care. In the Proposed Rule, CMS concedes that "[i]n the case of the post acute transfer policy . . . we focused on overpayment . . . to the transferring hospital when a patient is prematurely discharged to another provider during the same episode of

[78] 72 Fed. Reg. at 4,803.

[79] 72 Fed. Reg. at 4,818.

illness."[80] In enacting this policy, Congress even stated that it was concerned about Medicare "pay[ing] twice for these [same] services provided in different settings."[81]

Thus, the 25 Percent Rule should not be expanded because it is clearly duplicative of existing Medicare policies.

h. *Potential alternatives.*

Although we strongly believe that it is inappropriate to expand the 25 Percent Rule to all subclause I LTC hospitals, if CMS insists on finalizing this proposal, we urge the agency to, at a minimum, provide a four-year phase-in period analogous to the transition period that was afforded to co-located HwHs in connection with implementation of the current 25 Percent Rule. In implementing that transition period, CMS noted that "[t]ransitions are a frequently incorporated feature of new Medicare payment policies."[82] There is no basis to treat other LTC hospitals, particularly grandfathered LTC HwHs, any differently in this regard.

Second, similar to the grandfathered protective status that CMS afforded existing LTC HwHs and those that were under development when it originally implemented the 25 Percent Rule, should CMS finalize its proposal to expand the Rule, the agency should also grandfather any existing subclause I LTC hospitals that are not subject to the current Rule, as well as those facilities that are under development.

2. Short Stay Outlier (SSO) Cases

As noted above, CMS is proposing to generally reduce LTC hospital payments to the IPPS rate for SSO cases where the covered LOS is equal to or less than the IPPS comparable threshold—the average length of stay plus one standard deviation for the same DRG at short-term acute care hospitals.[83]

a. *CMS incorrectly assumes that SSO patients do not need LTC hospital care.*

As justification for this revision to the SSO payment methodology, CMS cites concerns similar to those it expressed in support of the RY 2007 revision to the SSO policy and the proposed extension of the 25 Percent Rule—namely, its "belief that many LTC hospitals appear to be admitting some SSO patients that could have received the care at the acute care hospital."[84] As discussed above, this "belief" is wholly unsubstantiated.

As support for its revised payment methodology for SSO cases where a patient's covered LOS at the LTC hospital is less than or equal to the IPPS comparable threshold, CMS cites its determination, based on FY 2005 MedPAR data, that 42 percent of LTC hospital SSO discharges

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[80] 72 Fed Reg. at 4,811.

[81] H.R. Rep. No. 105-149, at 1334 (1997) (Conf. Rep.).

[82] 69 Fed. Reg. at 49,206.

[83] 72 Fed. Reg. at 4,806-07.

[84] 72 Fed. Reg. at 4,806.

had lengths of stay less than or equal to the IPPS comparable threshold.[85] According to CMS, the cases comprising this 42 percent of LTC hospital SSO cases "appear to be comparable to typical stays at acute care hospitals." CMS then concludes that it is "overpaying" for these SSO cases.[86] However, in drawing this conclusion, CMS does not explain why it believes that it is "appropriate to compare the covered LOS of a LTCH case grouped to a particular LTC-DRG to the ALOS plus one standard deviation for the corresponding DRG under the IPPS."[87] Neither does CMS take into account the reality that LTC hospital patients are medically more complex than patients in general acute care hospitals. Even short stay LTC hospital patients are sicker and present with more comorbidities than comparable patients in short-term acute care hospitals. Significantly, Medicare data show that short stay LTC hospital patients have stays that are much longer than the average general acute care hospital patient with the same diagnosis. These differences in lengths of stay reflect the complexities associated with treating LTC hospital patients—complexities that are present even if the patient's stay is shorter than the IPPS comparable threshold. This difference in complexity is further demonstrated by examining the lengths of stay of patients in general acute care hospitals that are transferred to a LTC hospital. These LOS data reveal that, in general, transfer patients have a LOS in general acute care hospitals that exceeds the geometric mean LOS for their DRGs.

b. *LTC hospitals cannot predict a patient's length of stay.*

In addition to its inappropriate comparison between patients admitted to LTC hospitals and those admitted to general acute care hospitals, CMS also draws a specious connection between discharges from general acute care hospitals and improper admissions of "SSO patients that could have received the care at the acute care hospital." According to CMS, "[w]e believe that when these patients are admitted to a LTC hospital for an extremely short stay, the LTC hospital appears to be serving as a step-down unit of the acute care hospital."[88] However, CMS does not cite any evidence of general acute care hospitals systematically discharging patients early to maximize reimbursements. Indeed, CMS's proposed revision to the SSO payment methodology appears to rest on the incorrect assumption that LTC hospitals can somehow predict a patient's length of stay. CMS fails to recognize the clinical reality that, when a patient is admitted to a LTC hospital, the patient does not present with discernable characteristics indicating whether he or she will be a short stay patient or have a "normal" length of stay. CMS's policy also does not acknowledge that some patients will expire shortly after admission to a LTC hospital. LTC hospitals must make their admissions decisions on the basis of the patient's medical condition at the time he or she presents for admission—not on speculation that the patient will be a SSO. Moreover, many LTC hospital admissions are referred from other providers based on the medical judgment of the referring physician.

Further, based on a review of 2004 MedPAR data, the proportion of SSO patients who present with diagnoses with the highest severity of illness and risk of mortality scores is consistent with that presented by longer stay patients within the same DRGs. In DRG 475, for example, approximately 93 percent of SSOs present an APR-DRG severity score of three or four. The

[85] 72 Fed. Reg. at 4,805.

[86] 72 Fed. Reg. at 4,806.

[87] 72 Fed. Reg. at 4,805.

[88] 72 Fed. Reg. at 4,806.

severity scores for non-SSO patients within this DRG are virtually the same, with 94 percent presenting with severity scores of three or four. The severity scores associated with other DRGs lead to the same conclusion – that, at the time of admission, the likelihood that a particular patient will be an SSO patient cannot be predicted based on severity of illness scores.

Thus, it is clear that LTC hospitals cannot predict the expected length of stay in a LTC hospital based on the information available at admission. Instead, LTC hospitals make these decisions based on a clinical evaluation of medical need. Currently, most LTC hospitals use tools such as the InterQual® Long-Term Acute Care Criteria to assess the appropriateness of a patient's admission, continued stay, and ultimate discharge. The InterQual® criteria are among those MedPAC has recommended using to define more precisely the level of care provided by LTC hospitals.[89] Many of Medicare's QIOs use similar criteria to evaluate LTC hospital admissions. LifeCare also uses the InterQual® criteria to guide its admissions decisions. A recent review of the QIO activity in seven of our hospitals revealed a statistically insignificant number of denials.

Nonetheless, CMS proposes to reduce payments to the IPPS rate for SSO cases where the covered LOS is equal to or less than the IPPS comparable threshold. We recognize CMS's concern that some short stay patients may not have been appropriately admitted to LTC facilities and therefore should not receive full LTC-DRG payments. However, there is simply no support for the assumption that short stay patients at LTC hospitals generally do not require the same level of service as longer stay patients. As noted above, a more effective method for ensuring proper LTC hospital admissions would be to adopt admissions criteria that would allow only for admissions of patients who are medically complex and in need of the services provided by LTC hospitals.

c. *The proposed revision to the SSO payment methodology is premature.*

According to CMS, "[it] continue[s] to be concerned about appropriate payment for SSO cases under the LTCH PPS, and therefore, [is] considering a policy change for the purpose of differentiating between those SSO cases that we believe are more appropriately admitted and treated at LTCHs as distinguished from those with a LOS that resemble cases typically treated at acute care hospitals."[90] However, as with the proposed expansion of the 25 Percent Rule, CMS is acting without allowing sufficient time to study and collect data on the impact of the current SSO payment methodology. It is especially important to conduct a thorough evaluation of the most recent changes to the SSO payment methodology because these changes were implemented to address the very same concerns over inappropriate LTC hospital admissions that CMS is now expressing.[91] Given that the current methodology was finalized less than one year ago, neither CMS nor the LTC hospital industry has had adequate time to evaluate whether CMS's concerns over inappropriate admissions have already been remedied by the current SSO payment methodology. We therefore urge CMS, as with the proposed extension of the 25 Percent Rule, to, at a minimum, withdraw the Proposed Rule provisions relating to the SSO payment methodology and allow time for all interested parties to examine relevant SSO data and determine whether additional changes are necessary to address inappropriate LTC hospital admissions.

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[89] *See* 2004 MedPAC Report, *supra* note 42, at 121-34.

[90] 72 Fed. Reg. 4,807.

[91] 71 Fed. Reg. at 27,878-79.

d. *CMS should propose specific regulatory language before it finalizes changes in its SSO policies.*

The Administrative Procedure Act provides that a notice of proposed rulemaking should include the "*terms* or substance of the proposed rule."[92] In this Proposed Rule, CMS has failed to meet this requirement because it has only described a general approach to revising the SSO policy, but has not provided any specific regulatory language that would be subject to public comment. Case law has held that general requests for comments constitute inadequate notice of proposed regulatory changes.[93] In this Proposed Rule, CMS states that "[w]e are interested in soliciting comments on this approach as well as suggestions as to alternative ways in which to address our concerns."[94] Thus, by CMS's own admission, the agency is interested in considering alternative approaches to its concerns and is not yet prepared to finalize any one policy that could be subjected to public comment. CMS should promulgate such a specific regulation before it finalizes any changes to the SSO policy.

B. Comment: "Proposed Changes to LTCH PPS Payment Rates for the 2008 LTCH PPS Rate Year"

1. The market basket update should be 3.2 percent, the most recent market basket estimate for FY 2008.

In the Proposed Rule, CMS proposes a market basket update of 0.71 percent—2.49 percent lower than the most recent market basket estimate of 3.2 percent. CMS asserts that this 2.49 percent reduction is an "an adjustment to account for the increase in case-mix in the prior period (FY 2005) that resulted from changes in coding practices rather than an increase in patient severity."[95] However, the 0.71 percent update is neither adequate to reimburse the actual cost increases experienced by LTC hospitals nor supported by relevant data. Combined with other payment adjustments proposed by CMS, a 0.71 percent market basket update would result in reimbursement below LTC hospitals' cost of care. Further, CMS's assertion that a reduction in the market basket update is appropriate to account for a case-mix increase resulting from changes in coding practices is not supported by the facts.[96] To date, CMS has provided no data to support its belief that some portion of the case-mix increase between FY 2004 and FY 2005 was due to anything other than real changes in patient severity.[97] CMS has also failed to justify its use of the 1.0 percent increase in real case-mix under the IPPS as a proxy for the case-mix increase under the LTC hospital PPS.[98] Absent such data, CMS's determination that 0.71 percent is the appropriate update amount is simply not credible.

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[92] 5 U.S.C. § 553(b) (emphasis added).

[93] *See United Church Board of World Ministries v. SEC*, 617 F. Supp. 837, 840 (D. D.C. 1985) (stating that "[a] general request for comments is not adequate notice of a proposed rule change").

[94] 72 Fed. Reg. at 4,808.

[95] *Id.* at 4,790.

[96] In fact, CMS has commented that "changes in the LTCH coding practices ... appear to be stabilizing as LTCHs become more familiar with a DRG-based system." 72 Fed. Reg. at 4,785.

[97] *See* 72 Fed. Reg. at 4,791.

[98] *See id.* at 4,792.

In addition, in its discussion of the appropriateness of implementing a budget neutrality requirement for the annual LTC-DRG update, CMS states that "the most recent such LTCH claims data primarily reflects changes in the resources needed by an average LTCH case in a particular LTC-DRG (and not changes in coding practices). Thus, we now believe it would be reasonable and appropriate to update the LTC-DRGs in a budget neutral manner, beginning in FY 2008, so that estimated aggregate payments under the LTCH PPS would be unaffected."[99] CMS's acknowledgment that the most recent LTC hospital claims data do not reflect changes in coding practices for purposes of determining whether to implement a budget neutrality requirement is inconsistent with its reliance on changes in coding practices to reduce the market basket update. Given that a 0.71 percent update would result in payment rates below the cost of care and therefore may imperil access to the service provided by LTC hospitals, CMS should give considerable weight to its own conclusion that changes in coding practices are not a significant factor contributing to changes in the claims data. We therefore strongly recommend setting the market basket update for RY 2008 at 3.2 percent.

2. One-Time Budget Neutrality Adjustment

With respect to the potential one-time budget neutrality adjustment to ensure 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 for future years,"[100] CMS states that it is not proposing to make this adjustment at this time.[101] We agree that this one-time adjustment is unnecessary at present and, moreover, strongly believe that CMS should not make this adjustment at any time. Given that CMS, as described above, implemented a number of Medicare payment reductions since the first year of the LTCH hospital PPS and is now proposing changes that would further reduce payments to LTC hospitals, any "significant difference between actual payments and estimated payments" in the first year of the LTC hospital PPS surely would have been offset by this time. Therefore, it should not be necessary for CMS to ever make this adjustment.

C. Comment: "LTC-DRG Classifications and Relative Weights"

CMS proposes to impose a budget neutrality requirement for the annual LTC-DRG reweighting such that, beginning with the LTC-DRG update for FY 2008, estimated aggregate LTC hospital PPS payments will be unaffected.[102] LifeCare agrees that such a budget neutrality requirement is appropriate because it is consistent with CMS's budget neutrality policy with regard to IPPS DRG reweighting.[103] However, CMS should continue to monitor the annual reweighting of LTC-DRGs to ensure that it does not result in the redistribution of payments from high acuity DRGs to lower acuity DRGs, pending implementation of revised certification criteria designed to screen out inappropriate cases.

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[99] *See id.* at 4,786.

[100] *Id.* at 4,802.

[101] *Id.* at 4,804.

[102] *Id.* at 4,845.

[103] This requirement is also included in the current House and Senate legislation discussed above.

V. CONCLUSION

We appreciate the opportunity to comment on the important issues raised by the Proposed Rule and urge you to address our concerns in a manner that fully protects Medicare beneficiaries' access to medically necessary LTC hospital services for complex conditions. We request that CMS carefully consider the recommendations offered above in determining appropriate Medicare payment levels for LTC hospitals. Please contact us if we can provide you with any additional information or assistance.

Sincerely,

/s

Jill Force
Executive Vice-President
LifeCare Holdings, Inc.

Submitter : **Ms. Laura Loeb** **Date: 03/26/2007**

Organization : **American Dental Education**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Background

Background

Comments per Federal Register 2/07

GENERAL

GENERAL

See attachment

CMS-1529-P-131-Attach-1.DOC

CMS-1529-P-131-Attach-2.DOC

#131

March 26, 2007

The Honorable Leslie V. Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 443-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201
Attention: CMS-1529-P

RE: Medicare Program: Prospective Payment System for Long Term Care Hospitals FY 2008 - Proposed Annual Payment Rate Updates and Policy Changes and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes - CMS -1529-P

Dear Administrator Norwalk:

The American Dental Education Association (ADEA) appreciates the opportunity to comment on the proposed rule for changes to long term care hospitals that includes proposed policy changes for direct and indirect graduate medical education funding, as published in the February 1, 2007 *Federal Register*. Specifically, we will comment on the proposed changes to graduate medical education (GME) policies.

ADEA is the national organization that speaks for dental education. It is dedicated to serving the needs of all 56 U.S. dental schools, 731 U.S. dental residency programs, 266 dental hygiene programs, 259 dental assisting programs, and 25 dental laboratory technology programs, as well as the 11,332 full- and part-time dental school faculty, more than 5,060 dental residents (both hospital- and school-based) and the nation's 36,286 dental and allied dental students.

Proposed GME Changes

CMS has proposed that for training occurring in a nonhospital setting, a hospital will be required to incur only 90 percent of the sum of residents' stipends and benefits (and any travel and lodging costs) plus the cost of faculty supervisory teaching time, as opposed to 100% of these costs. In addition, CMS is proposing a set formula to use to calculate supervisory teaching time. This formula would use as a proxy for supervisory teaching time that is 3 hours divided by the number of hours that the nonhospital site is open per week. Programs would have the option of using actual costs for the faculty time or this new formula.

We support these changes as providing more administrative ease to an already difficult process. We would simply urge CMS to reiterate very clearly in the final rule that hospitals and nonhospital training sites are still able to negotiate payments from the hospital for faculty training costs that are greater than the costs generated by the formula.

We understand that this proposed rule was issued primarily to address the issue of volunteer faculty. We believe that faculty can and do volunteer their supervisory teaching time. We also would urge CMS to fully recognize all situations where that occurs. In those situations, no calculation of faculty costs would be necessary.

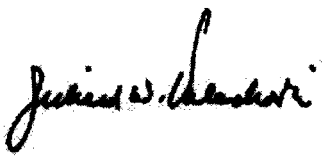
However, while faculty costs can be very low, we are also aware that faculty supervisory teaching costs can be greater than the costs this formula using proxy hours would identify. Nonhospital sites must have the opportunity to negotiate with hospitals for full reimbursement of these supervisory teaching costs.

We would agree with CMS that the actual supervisory teaching costs often are very difficult for the hospital and nonhospital site to determine. First, teaching practitioners have a difficult time differentiating teaching time from patient care time from research time and from administrative time. These four categories often overlap. Having the teaching practitioners in nonhospital sites complete time/effort reports has proven burdensome for these practitioners and for the hospitals. Further, these reports often are not accurately completed because of differing perspectives on what is supervisory teaching time and because workload responsibilities can differ from one two-week period to another.

By developing this formula, CMS appears to be recognizing the limitations of time/effort reports in the nonhospital setting and also acknowledging that faculty costs can be supported in other manners. Relying on the proxy formula where there are no time/effort reports or these reports appear to be unreliable would at least provide a baseline figure to use as faculty costs.

In addition, we would also note that for dental programs, CMS should use average compensation figures for dental faculty based on specialty and region of the country. We would be happy to work with CMS staff to develop those compensation figures for the formula for dental programs. Thank you for this opportunity to comment on this proposed rule. If you have any further questions regarding these comments, please contact Jack Bresch, Associate Executive Director of ADEA, at 202/289-7201.

Respectfully submitted by,



Richard Valechovic
Executive Director

Submitter : Ms. Jill L. Force **Date:** 03/26/2007

Organization : LifeCare Hospitals

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment. Difficulty with uploading previous letter.

CMS-1529-P-132-Attach-1.PDF

#132

LIFECARE
HOSPITALS

March 26, 2007

By Electronic Mail

Leslie V. Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1529-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-1529-P; Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates and Policy Changes; Proposed Rule

Dear Acting Administrator Norwalk:

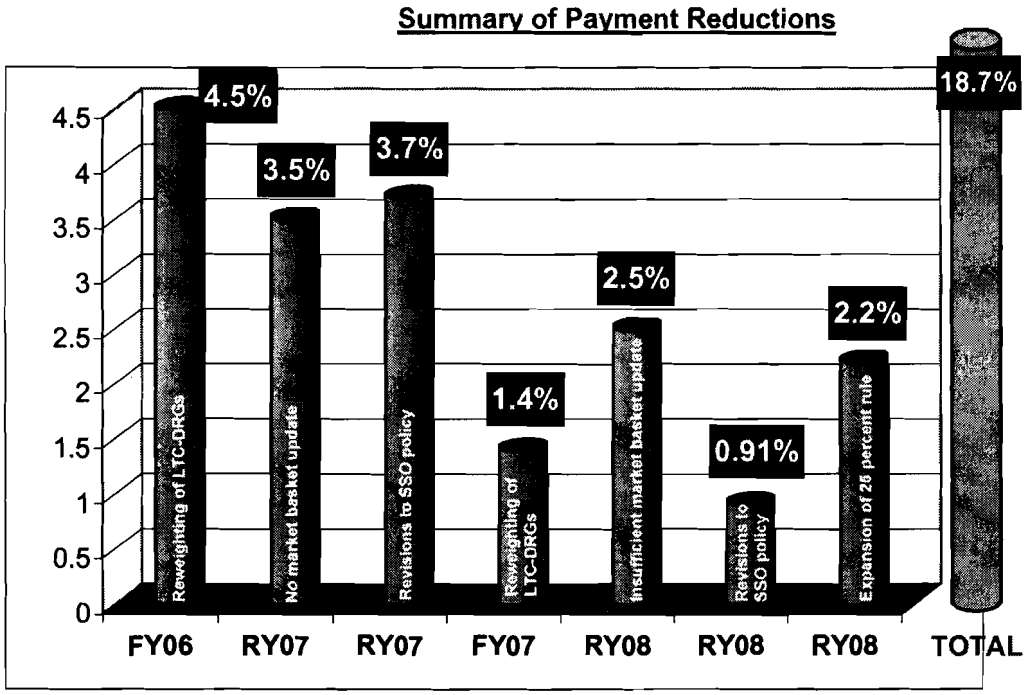
On behalf of LifeCare Holdings, Inc. ("LifeCare"), which owns and operates long-term acute care hospitals, I am writing to comment on the Centers for Medicare & Medicaid Services' proposed rule entitled "Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates and Policy Changes" (the "Proposed Rule").[1] We appreciate this opportunity to comment on the Proposed Rule and look forward to working with CMS to ensure that these provisions are implemented in a manner that reflects our concerns.

I. EXECUTIVE SUMMARY

The Proposed Rule presents flawed Medicare payment policies predicated on a number of fundamental misconceptions about the long-term care ("LTC") hospital industry. If finalized, the Rule would result in severe Medicare payment reductions for LTC hospitals. These reductions, which CMS estimates as having an aggregate impact on the LTC hospital industry of 2.9 percent, or $117 million, would exacerbate the effects of the already substantial cuts that LTC hospitals have experienced in recent years. Specifically, when added to the payment reductions experienced in 2005 and 2006, implementation of the Proposed Rule would mean that LTC hospitals would have

[1] 72 Fed. Reg. 4,776 (proposed Feb. 1, 2007).

seen their reimbursement decline by more than 18.7 percent over a three-year span, as demonstrated below:



That CMS is proposing to implement these cuts at this time is particularly mystifying because, as discussed more fully below, the payment reductions implemented in recent years have significantly reduced Medicare margins for LTC hospitals and appear to have substantially slowed the recent growth in these facilities.

For LifeCare in particular, we anticipate that implementation of the Proposed Rule would result in Medicare payment reductions of up to $24 million per year. Faced with such large losses, we may have no choice but to consider closing several of our hospitals. Thus, these payment reductions could prevent us from continuing to provide high-quality care to many of the medically complex beneficiaries who are treated at our hospitals.

We have a number of specific concerns about the Proposed Rule, which are summarized below:

A. Expansion of the 25 Percent Rule

1. To address its concerns over the appropriateness of LTC hospital admissions, CMS should implement patient and facility criteria rather than expand the 25 Percent Rule.

CMS proposes to remedy the perceived problem of Medicare making two payments for one episode of care by expanding the "25 Percent Rule," which currently limits LTC hospital hospitals

within hospitals ("HwHs") to the general inpatient prospective payment system ("IPPS") rate if more than 25 percent of admissions are referred from the host hospital, to all Medicare discharges from LTC hospitals and LTC hospital satellites admitted from non-co-located hospitals as well as grandfathered LTC HwHs and LTC hospital satellites. While this remedy would certainly reduce payments to LTC hospitals for certain admissions from general acute care hospitals, expansion of the 25 Percent Rule would not meaningfully address the fundamental issue that CMS says it is trying to resolve: inappropriate admissions to LTC hospitals from short-term acute care hospitals. Instead, it would impede legitimate access to highly specialized, necessary care. To address the issue of inappropriate admissions, CMS should implement patient and facility criteria for LTC hospitals, as both the Medicare Payment Advisory Commission ("MedPAC"), Congress's advisory body on Medicare matters, and the Research Triangle Institute ("RTI"), the independent entity that CMS commissioned to study this question, have recommended. Further, two bills recently introduced in the 110th Congress, the Medicare Long-Term Care Hospital Improvement Act of 2007 (S. 338 and H.R. 562), demonstrate strong Congressional support for the proposition that CMS should implement patient and facility criteria in lieu of making arbitrary payment reductions.

2. The proposed expansion of the 25 Percent Rule is arbitrary and unsupported by the evidence.

Although inappropriate LTC hospital admissions arising from certain business relationships between short term acute care hospitals and LTC hospitals would be a legitimate concern for CMS if they existed, CMS's solution to this perceived problem—expansion of the 25 Percent Rule—is not supported by any credible evidence. CMS is instead relying on "anecdotal" evidence of inappropriate relationships between short-term acute care hospitals and LTC hospitals and drawing an unsubstantiated connection between referrals from short-term care hospitals and purported arrangements to engage in patient shifting. Implementing an expanded 25 Percent Rule on the basis of anecdotal evidence and conjecture is wholly unsupported and legally suspect.

3. Expansion of the 25 Percent Rule would force LTC hospitals into an unsustainable financial position.

Although CMS claims that LTC hospitals may minimize the effect of the Proposed Rule by adjusting their admissions policies, the Medicare regulations restrict LTC hospitals from denying admission to Medicare beneficiaries. Under the regulations, a Medicare provider may not have different admissions criteria for Medicare patients than for all other patients. Therefore, expansion of the 25 Percent Rule would force LTC hospitals into the untenable financial position of having to admit high-cost patients without receiving adequate payment for the services they provide those patients.

4. In proposing an expansion of the 25 Percent Rule, CMS ignores fundamental principles of PPS.

The Proposed Rule would violate the principle that Medicare pays hospitals on the basis of the average costs of delivering care—the fundamental premise of PPS. Under the Proposed Rule, LTC hospitals would continue to accept the sicker, more medically complex patients that are typical for LTC hospitals but, after reaching the 25 percent threshold, would be unable to receive payments adequate to offset the costs of treating these severely ill individuals. Over time, payment would be shifted away from reimbursing for the average costs of care to a punitive payment system under

which LTC hospitals would be certain to incur financial losses for a large percentage of their patients.

5. The proposed expansion of the 25 Percent Rule to grandfathered HwHs violates Congressional intent and is not supported by the evidence.

In the Balanced Budget Act of 1997, Congress made clear its intent to protect grandfathered HwHs from application of the HwH rules. Throughout the implementation of the LTC hospital PPS and the adoption of the existing 25 Percent Rule, CMS has recognized the special status that Congress granted these hospitals, and has specifically acknowledged that the 25 Percent Rule does not apply to these facilities. For their part, grandfathered LTC hospitals have relied for years on these CMS statements. The Proposed Rule unfairly penalizes hospitals that relied on this historic treatment, and applying the 25 Percent Rule to grandfathered HwHs at this time may very well result in the closure of many of these facilities. As with the proposed expansion of the 25 Percent Rule to freestanding LTC hospitals, CMS offers no evidence in the Proposed Rule to support this abrupt departure from long-standing policy.

6. The proposed expansion of the 25 Percent Rule is premature.

The current 25 Percent Rule is designed to address many of the concerns regarding inappropriate LTC hospital admissions in the specific setting where CMS believes they are most likely to be generated. Therefore, before implementing an expansion of this policy, CMS should allow sufficient time to study and collect data on the impact of the existing Rule, which was phased in over a four-year period that ends in FY 2008. CMS itself acknowledges, in its discussion in the Proposed Rule of the one-time budget neutrality adjustment, that there is great value in evaluating the most current data available before making important payment policy decisions.

7. Existing CMS policies already address concerns about patient shifting.

Medicare regulations have already been implemented to discourage patient shifting, including the post acute care transfer policy. This policy was created because of the same concerns that CMS articulated in the Proposed Rule, i.e., that general acute care hospitals are discharging patients too early, resulting in two payments for one episode of care. Thus, the 25 Percent Rule should not be expanded because it is clearly duplicative of existing Medicare policies.

B. Expansion of the SSO Policy

As with the proposed expansion of the 25 Percent Rule, CMS's rationale for revising the short stay outlier ("SSO") payment methodology rests largely on unfounded assumptions that LTC hospitals are improperly admitting patients from general acute care hospitals, that payment based on an "IPPS comparable threshold" is an appropriate method for paying LTC hospitals, and that LTC hospitals are somehow able to predict a patient's length of stay. Here again, CMS does not provide any evidence to support these assumptions. Furthermore, as with the proposed expansion of the 25 Percent Rule, CMS's proposal is premature. Neither CMS nor LTC hospitals have had sufficient time to evaluate the effects of the current SSO payment methodology, which was implemented less than one year ago. At a minimum, CMS should allow all interested parties an opportunity to ascertain the impact of these recent changes before embarking upon yet another refinement of this

methodology. CMS should also propose specific regulatory language before it finalizes these changes.

C. Market Basket Update for RY 2008

The proposed 0.71 percent market basket update would result in reimbursement rates below the cost of care and CMS has not offered any evidence supporting its contention that a downward adjustment to the update is necessary to account for changes in coding practices. We therefore strongly recommend setting the market basket update for RY 2008 at the most recent market basket estimate for that year of 3.2 percent.

D. One-Time Budget Neutrality Adjustment

LifeCare believes that a one-time budget neutrality adjustment is unnecessary at this time, or at any future time. The purpose of the adjustment is to ensure 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 for future years."[2] CMS has made, and continues to propose, significant Medicare payment reductions to LTC hospitals and any "significant differences" between actual and estimated payments in the first year of the LTC hospital PPS surely would have been offset by this time. CMS should not make this adjustment in this rate year or any future rate year.

E. Budget-Neutral Reweighting of LTC-DRGs

LifeCare agrees that a budget neutrality requirement for reweighting of LTC-DRGs is appropriate because it is consistent with CMS's policy with respect to IPPS DRG reweighting. However, CMS should continue to monitor the annual reweighting of LTC-DRGs to ensure that it does not result in the redistribution of payments from high acuity DRGs to lower acuity DRGs, pending implementation of revised certification criteria designed to screen out inappropriate cases.

II. BACKGROUND

A. Company and Industry Background

LifeCare was founded in 1993. We currently operate 20 LTC hospitals, with 893 licensed beds in nine states. Two of these hospitals, located in Shreveport, Louisiana, are currently "grandfathered" from application of the 25 Percent Rule. Our facilities employ approximately 2,800 people in various clinical and support capacities.

LTC hospitals provide high levels of inpatient care for far longer periods than short-term acute care hospitals. Because of their high acuity patients, LTC hospitals often require more resources to provide patient care than do short-term care hospitals. As MedPAC stated in its March 2007 report, "LTCHs provide care to patients with clinically complex problems, such as multiple acute or chronic conditions, who need hospital-level care for relatively extended periods."[3]

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[2] *Id.* at 4,802.

[3] Medicare Payment Advisory Comm'n, *Report to the Congress: Medicare Payment Policy* 219 (2007) (hereinafter "MedPAC report").

Therefore, in developing or modifying payment rates for LTC hospitals, it is important to distinguish them from rehabilitation facilities, psychiatric facilities, and skilled nursing facilities. These other alternatives to short-term care hospitals treat patients with conditions that are less likely to be associated with the higher acuities experienced by LTC hospital patients.

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

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

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

Significantly, RTI has specifically recognized the unique and important role that LTC hospitals play in the U.S. health care system, nothing that "[t]he majority of LTCH admissions are medically complex and there is general consensus that these cases need the more intensive treatment programs provided by LTCHs."[4]

[4] Barbara Gage, Ph.D., et al., *Long-Term Care Hospital (LTCH) Payment System Monitoring and Evaluation* 131 (2006) [hereinafter "RTI Study"].

B. The History of LTC Hospital Medicare Payments

Congress and CMS have long recognized that LTC hospitals have unique characteristics that require special payment status under the Medicare Program.[5] LTC hospitals, like many providers, were formerly reimbursed on the basis of their reasonable costs, subject to the cost limits established under Section 223 of the Social Security Act Amendments of 1972.[6] In 1982, Congress passed the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"),[7] which required the Secretary "to develop, in consultation with the Senate Finance Committee and House Ways and Means Committee, [M]edicare prospective reimbursement proposals for hospitals, skilled nursing facilities and to the extent feasible other providers."[8]

Significantly, prior to the enactment of TEFRA, the House of Representatives initially approved legislation that instructed the Secretary to develop a prospective payment system for both short-stay and long-stay hospitals, stating that "the Secretary [is] to develop and to submit to Congress by December 31, 1982, a Medicare prospective payment plan for hospital inpatient services and extended care services designed to take effect October 1, 1983. . . ."[9] However, the House-Senate Conference rejected this language, thus clearly indicating that Congress recognized the special problems a prospective payment system presents for extended care hospital services. Subsequently, the Secretary's response to the TEFRA Congressional directive to develop prospective reimbursement proposals stated that "467 DRGs were not designed to account for these types of [extended care] treatment" and that applying them to LTC hospitals "would be inaccurate and unfair."[10] Based on these findings and pursuant to its statutory discretion, CMS exempted LTC hospitals from the Section 223 limits on reasonable costs, noting that "[d]ata from long-term care hospitals are not adequate to include them in a system of case-mix adjusted limits based primarily on records from general short-term acute care hospitals."[11]

This recognition of the unique nature of LTC hospitals was reinforced in 1983 when Congress mandated implementation of a prospective payment system for most hospitals but specifically exempted LTC hospitals.[12] In enacting this provision, Congress expressly noted that "[t]he DRG system was developed for short-term acute care general hospitals and, as currently constructed, does not adequately take into account special circumstances of diagnoses requiring

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

[6] Social Security Amendments of 1972, Pub. L. No. 92-603, § 223, 86 Stat. 1329 (1972).

[7] Tax Equity & Fiscal Responsibility of 1982, Pub. L. No. 97-248, § 101, 96 Stat. 331 (1982) (codified at 42 U.S.C. § 1320b-5).

[8] *Id.*

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

[10] 67 Fed. Reg. 55,954, 55,957 (Aug. 30, 2002) (*quoting* HHS Report: "Hospital Prospective Payment for Medicare" (1982)).

[11] 47 Fed. Reg. 43,296, 43,299 (Sept. 30, 1982).

[12] Social Security Amendments of 1983, Pub.L. No. 98-21, § 601(d)(1)(B)(iv), 96 Stat. 331 (codified as amended at 42 U.S.C. §1395f, 1395e) (excluding from PPS "a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days").

long stays."[13] Thus, it is clear that, for almost 25 years, Congress and CMS have recognized that IPPS is an inadequate payment methodology for LTC hospitals.

In the FY 1995 IPPS Final Rule, CMS first recognized LTC hospitals within hospitals, i.e., hospitals that occupy space in a building also used by another hospital, or in one or more separate buildings located on the same campus as buildings used by another hospital.[14] In this rulemaking, CMS noted that LTC hospital "units" are statutorily prohibited and that the agency was concerned LTC hospital HwHs were acting as units.[15] To address this concern, CMS established separateness and control criteria for LTC HwHs, which required that HwHs establish functional and organizational separateness from their host hospitals so as not to operate as "units."[16] These separateness criteria include, for example, requirements that LTC HwHs establish separate governing bodies, chief medical officers, executive officers, and medical staff from their host hospitals.[17] The principal objective of these criteria was to address the shifting of costly, long-stay patients from host hospitals to on-site LTC hospitals, resulting in two hospital stays which would result in a financial windfall for both providers.[18] LTC hospitals not meeting these criteria could not retain their exempt status. Significantly, at the time, CMS exempted from the separateness and control criteria for a hospital's first cost reporting period beginning on or after October 1, 1995 those hospitals that had been excluded from PPS for any cost reporting period beginning on or after October 1, 1993 but before October 1, 1995.[19] In the Balanced Budget Act ("BBA") of 1997, Congress enacted a statutory "grandfathering" of certain HwHs from application of the separateness and control criteria, providing that "a hospital that was classified by the Secretary on or before September 30, 1995, as an excluded long-term care hospital shall continue to be so classified notwithstanding that it is located in the same building as, or on the same campus as, another hospital."[20] This statutory enactment led to the promulgation of grandfathering provisions in the IPPS regulations.[21]

In the Balanced Budget Refinement Act of 1999 ("BBRA"),[22] Congress directed the Secretary to develop and implement a DRG-based PPS for LTC hospitals.[23] This mandate was revised by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000

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[13] H.R. Rep. No. 98-25, at 141 (1983). *See also* S. Rep. No. 98-23, at 54 (1983) ("The DRG classification system was developed for short-term acute care general hospitals and, as currently constructed, does not adequately take into account special circumstances of diagnoses requiring long stays and as used in the medicare program is inappropriate for certain classes of patients").

[14] 59 Fed. Reg. 45,330, at 45,389 (Sept. 1, 1994); 42 C.F.R. § 412.22(e).

[15] 59 Fed. Reg. at 45,389.

[16] *Id.* at 45,396-97; 42 C.F.R. § 412.22(e).

[17] *See* 42 C.F.R. § 412.22(e)(1)(i) – (v).

[18] *See* 72 Fed. Reg. at 4,809. Separateness and control criteria were later established for LTC satellites in the FY 2005 IPPS final rule.

[19] 59 Fed. Reg. 45,396-97.

[20] Balanced Budget Act of 1997, Pub. L. No. 105-33 at § 4417, 11 Stat. 251 (to be codified at 42 U.S.C. § 1395ww).

[21] 42 C.F.R. § 412.22(f); *see also* 62 Fed. Reg. 45,966 (Aug. 29, 1997).

[22] Balanced Budget Refinement Act of 1999, Pub. L. No. 106-113, 113 Stat. 1501A-331.

[23] *Id.* at § 123.

("BIPA"),[24] which required the Secretary to "examine the feasibility and the impact of basing payment under such a system on the use of existing (or refined) hospital diagnostic related groups ("DRGs") that have been modified to account for different resource use of long-term care hospital patients as well as the use of the most recently available hospital discharge data."[25] In addition, BIPA noted that, if the Secretary were unable to implement a PPS for such hospitals by October 1, 2002, she was to implement a PPS using the existing acute care hospital DRGs, "modified where feasible to account for resource use of long-term care hospital patients using the most recently available hospital discharge data for such services. . . ."[26] Thus, in directing the Secretary to modify the DRGs to reflect different resource usage levels among various provider types, Congress reiterated its historic finding that general acute care hospitals and LTC hospitals provide different levels of care, and that the payment methodologies for these facilities should reflect this reality.

The Final Rule implementing the LTC hospital PPS was promulgated on August 30, 2002.[27] In that Rule, CMS noted the policy underlying any PPS—that hospitals will incur costs in excess of payments for some patients and costs below payments for others, and that an efficiently operated facility should be able to deliver care at an overall cost that is at or below the reimbursement rate.[28] CMS also recognized the inappropriateness of directly applying a general acute care PPS to LTC hospitals, noting that "Congress excluded these hospitals from the acute care hospital inpatient prospective payment system because they typically treated cases that involved stays that were, on average, longer or more costly than would be predicted by the DRG system. . . . [T]hese hospitals could be systemically underpaid if the same DRG system were applied to them."[29]

In recent years, the LTC hospital PPS has undergone a number of changes which have subjected LTC hospitals to several significant Medicare payment reductions. One important change was the establishment of the current 25 Percent Rule in the FY 2005 IPPS final rule.[30] This Rule generally provided that, if an LTC HwH's or LTC hospital satellite's discharges that were admitted from its host hospital exceeded 25 percent of its total Medicare discharges for a cost reporting period, that LTC HwH or LTC hospital satellite would receive an adjusted payment equaling the lesser of the amount otherwise payable under the LTC hospital PPS or an amount equivalent to what Medicare would otherwise pay under the IPPS.[31] The introduction of the 25 Percent Rule was phased in over a four-year transition period ending in FY 2008. CMS also provided that LTC HwHs that were grandfathered from the application of the separateness and control criteria would not be subject to the 25 Percent Rule.[32]

In the past two years, a number of additional payment reductions have further reduced Medicare payments for LTC hospitals. In the IPPS Final Rule for FY 2006, CMS made substantial

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[24] Benefits Improvement and Protection Act of 2000, Pub. L. No. 106-554, 114 Stat. 2763A-496.

[25] *Id.* at § 307(b)(1).

[26] *Id.* at § 307(b)(2).

[27] 67 Fed. Reg. 55,954 (Aug. 30, 2002).

[28] *Id.* at 55,957.

[29] *Id.*

[30] 69 Fed. Reg. 48,916 (Aug. 11, 2004).

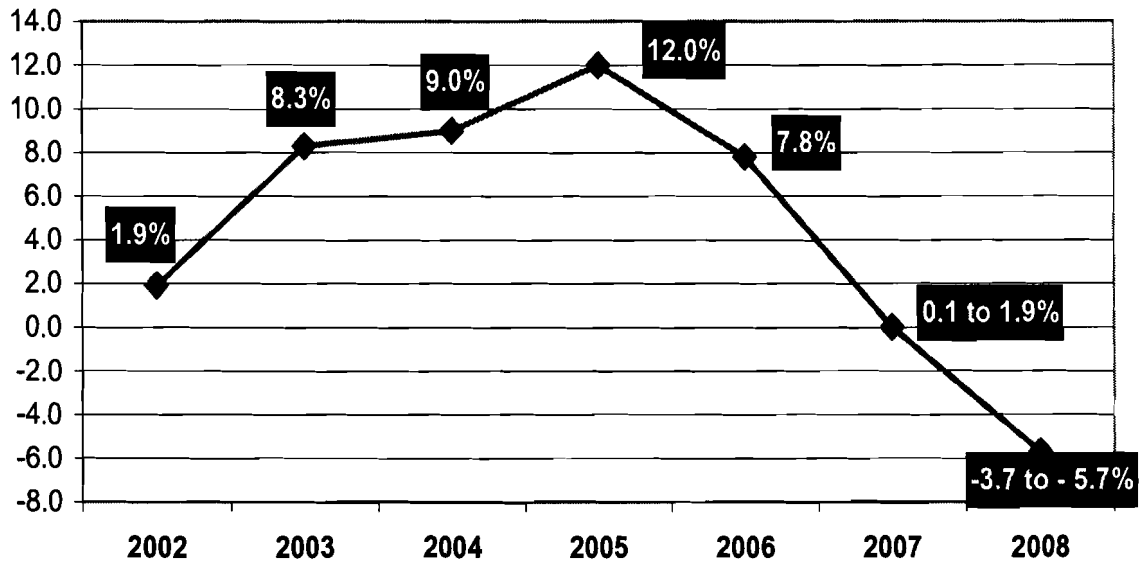
[31] *Id.* at 49,194; 42 C.F.R. § 412.534.

[32] 69 Fed. Reg. at 49,213; 42 C.F.R. § 412.534.

revisions to the weights for LTC-DRGs, resulting in an estimated 4.5 percent payment reduction.[33] In the LTC hospital PPS Final Rule for RY 2007, CMS adopted a zero percent market basket update, notwithstanding that LTC hospital costs increased by 3.6 percent in that year.[34] In this Final Rule, CMS also revised the payment methodology for short stay outliers by providing that LTC hospitals would be reimbursed for SSOs based on a blend of an amount comparable to the IPPS per diem payment amount and 120 percent of the LTC-DRG per diem payment amount.[35] This revision was expected to result in a 3.7 percent payment reduction for LTC hospitals in RY 2007.[36] In the IPPS Final Rule for FY 2007, CMS again reduced LTC hospital payments by reweighting the LTC-DRGs, which amounted to a 1.4 percent reimbursement cut.[37] Thus, the cumulative impact of these cuts over this two-year period was approximately 13.2 percent.

As a result of these payment reductions, LTC hospitals' Medicare margins have also dramatically declined. MedPAC reports that, while the LTC hospital Medicare margin in 2005 was approximately 12 percent, the margin for 2007 was estimated to be between 0.1 percent and 1.9 percent.[38] Significantly, MedPAC issued this estimate *before* promulgation of the Proposed Rule. When the proposed reductions are included in the margin analysis, we estimate that LTC hospital margins for 2008 would plummet to a *negative* 3.7 to 5.7 percent. These changes, summarized below, are unprecedented and ultimately unsustainable.

LTC Hospital Medicare Margins



[33] *See* 70 Fed. Reg. 47,277 (Aug. 12, 2005).

[34] 71 Fed. Reg. 27,798, 27,817 (May 12, 2006).

[35] 42 C.F.R. § 412.529.

[36] 71 Fed. Reg. at 27,803.

[37] 71 Fed. Reg. 47,870, at 47,971-47,994 (Aug. 18, 2006).

[38] MedPAC report, *supra* note 3, at 220.

As a result of these reduced payments and margins, the LTC hospital industry has also experienced a sharp slowdown in growth. In 2006, there was a net reduction in the number of LTC hospitals -- nine hospitals left the Medicare system, and only eight new hospitals were certified.

III. THE PROPOSED RULE

In this Proposed Rule, CMS is proposing a number of Medicare payment changes that, if finalized, could have a further devastating impact on LifeCare hospitals, the LTC hospital industry as a whole, and the patients we serve. Most significantly, CMS is proposing to:

- Extend the 25 Percent Rule to non-co-located hospitals, thereby extending the 25 Percent Rule to all "subclause (I)"[39] LTC hospitals;
- Extend the 25 Percent Rule to "grandfathered" HwHs and LTC hospital satellites;
- Reduce payments to the IPPS rate for SSO cases where the covered length of stay ("LOS") is less than or equal to the "IPPS comparable threshold"—defined as the average length of stay plus one standard deviation for the same DRG at short-term acute care hospitals; and
- Implement a market basket update of 0.71 percent.

The Proposed Rule also proposes to delay consideration of a one-time budget neutrality adjustment for the LTC hospital PPS and imposes a budget neutrality requirement for the annual reweighting of LTC-DRGs.

As described above, LTC hospitals provide services to patients who are demonstrably sicker, have higher acuities, and have more comorbidities than patients in the typical short-term acute care hospital. If implemented in its current form, the Proposed Rule would threaten these patients' ability to obtain high levels of care in the most appropriate setting. LifeCare anticipates that implementation of the Proposed Rule would result in Medicare payment reductions for its hospitals of up to $24 million per year. A significant portion of these reductions would result from the proposed expansion of the 25 Percent Rule to grandfathered HwHs. We are very concerned that, if the Rule is finalized as proposed, LifeCare may have to seriously consider closing several of our facilities. Presumably, many other similarly situated LTC hospital providers would also face these difficult choices. Thus, if implemented, the Proposed Rule could call into question the long-term financial viability of the LTC hospital industry and prevent many LTC hospitals from continuing to provide high-quality care to a particularly vulnerable class of Medicare beneficiaries.

[39] "Subclause (I)" LTC hospitals are defined as a "hospital which has an average inpatient length of stay ... of greater than 25 days...." 42 U.S.C. § 1395ww(d)(1)(B)(iv)(I). A "subclause II" hospital is one that has an average inpatient length of stay of greater than 20 days and has 80 percent or more of its annual Medicare inpatient discharges with a principal diagnosis that reflects a finding of neoplastic disease. 42 U.S.C. § 1395ww(d)(1)(B)(iv)(II).

IV. DISCUSSION

A. Comment: "Other Proposed Policy Changes for the 2008 LTCH PPS Rate Year"

1. The 25 Percent Rule

a. *To address its concerns over the appropriateness of LTC hospital admissions, CMS should implement patient and facility criteria rather than expand the 25 Percent Rule.*

The expansion of the 25 Percent Rule described in the Proposed Rule is largely predicated on CMS's belief that acute care hospitals "prematurely discharge Medicare patients to LTC hospitals for additional treatment during the same episode of care," thereby "generating two payments under two different payment systems for what was essentially one episode of beneficiary care."[40] CMS's proposed remedy for this perceived problem is to expand the 25 Percent Rule to grandfathered LTC hospital HwHs and LTC hospital satellites and to all Medicare discharges from subclause (I) LTC hospitals and LTC hospital satellites admitted from non-co-located hospitals.[41] However, this remedy fails to directly address the issue of inappropriate LTC hospital admissions. Instead, it would result in arbitrary payment reductions that lack any direct link to the level or quality of services provided by LTC hospitals and, as described above, would jeopardize the financial viability of the LTC hospital industry and impede patient access to LTC hospital services.

Rather than arbitrarily cutting payments and placing patients at risk, if CMS's goal is to ensure that patients are properly admitted to LTC hospitals, it should adopt a criteria-based system that would only permit the admission of patients who are medically complex and in need of the services provided by these facilities. MedPAC and its predecessor, the Prospective Payment Assessment Commission (ProPAC), have been on the record for nearly a decade recommending that the Secretary address this issue by defining LTC hospital eligibility and patient admissions criteria so as to ensure appropriate admissions.[42] For example, in its June 2004 report, MedPAC recommended that the certification criteria for LTC hospitals be strengthened to ensure that Medicare payments are made only to those providers that are administering medically complex care to severely ill patients.[43] MedPAC staff has observed that it should take CMS less than a year's time to develop such criteria.[44] Of note, MedPAC has also commented that the 25 Percent Rule does not ensure that patients will be treated in the most appropriate post-acute care setting.[45] For its part, CMS has expressed agreement with the concept of implementing patient and facility criteria

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[40] 72 Fed. Reg. at 4,812.

[41] *Id.* at 4,813.

[42] *See, e.g.*, 62 Fed. Reg. 29,902, 29,928 (Jun. 2, 1997) ("ProPAC has recommended that [CMS] ... evaluate whether the current Medicare certification rules that apply to these facilities should be changed...."); Medicare Payment Advisory Comm'n, *Report to the Congress, New Approaches in Medicare* 130 (2004) (hereinafter "2004 MedPAC report") ("The Congress and the Secretary should define long-term care hospitals by facility and patient criteria that ensure that patients admitted to these facilities are medically complex and have a good chance of improvement").

[43] 2004 MedPAC report, *supra* note 42, at 120.

[44] *See* Transcript, MedPAC Public Meeting, "Assessment of Payment Adequacy: Long Term Care Hospitals" at 264, 267 (Jan. 9, 2007).

[45] Letter from MedPAC to Dr. Mark McClellan, Adm'r, CMS, at 10 (July 9, 2004).

for years, but, for reasons that are difficult to fathom, has been unable to follow through on these recommendations.[46]

As you are aware, in response to the June 2004 MedPAC report, CMS contracted with RTI to examine the feasibility of implementing MedPAC's recommendations.[47] This report, published in January 2007, made recommendations on the establishment of patient and facility criteria that were nearly identical to MedPAC's.[48]

Consistent with the MedPAC and RTI recommendations, LifeCare urges the development of patient and facility criteria that, among other things: (1) measure patient characteristics to ensure that only medically complex patients are admitted to LTC hospitals; (2) ensure that LTC hospitals are capable of supporting the care of these high acuity patients; and (3) condition LTC hospital stays on appropriate patient medical complexity. Establishing such criteria would help reduce the number of admissions CMS perceives to be "inappropriate" without jeopardizing patient access to the appropriate level of care provided by LTC hospitals.

Recent actions by Members of Congress also demonstrate strong bipartisan Congressional support for establishing patient and facility criteria, rather than payment reductions, as the more effective method for ensuring appropriate LTC hospital admissions. At the end of the 109th Congress, Congressmen Phil English (R-PA) and Earl Pomeroy (D-ND) introduced legislation that would, among other things, define LTC hospitals with reference to specific facility criteria and establish patient criteria to ensure that LTC hospitals serve medically complex patients.[49] The legislation also contained an express prohibition on expansion of the 25 Percent Rule to freestanding LTC hospitals. Further, in April of last year, members of both the House and Senate sent letters to the CMS Administrator and the Secretary, respectively, urging CMS to establish LTC hospital patient and facility criteria.[50] The LTC hospital legislation was re-introduced by Congressmen English and Pomeroy in the 110th Congress (H.R. 562), and Senators Kent Conrad (D-ND) and Orrin Hatch R-UT) have introduced similar legislation in the Senate (S. 338).[51] According to estimates by the Acute Long Term Hospital Association, this legislation would reduce Medicare spending on LTC hospitals by approximately $1-2 billion over five years.

Finally, in the Final Rule implementing the 25 Percent Rule for co-located LTC HwHs, CMS stated that "[p]rior to the end of the 4 year transition period, [it] will reevaluate the HwHs criteria to assess the feasibility of developing facility and clinical criteria for determining the appropriate facilities and patients to be paid for under the Medicare LTCH PPS. If, during that time period, data

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[46] *See, e.g.*, 69 Fed. Reg. at 49,213 ("We agree with commenters that it may be worthwhile to examine patient and facility issues. Further examining of these issues may be beneficial in establishing the most effective and cost-efficient utilization of LTCHs and in assuring that Medicare beneficiaries receive the appropriate level of treatment and care in that setting.").

[47] 71 Fed. Reg. at 4,818.

[48] RTI Study, *supra* note 4.

[49] *See* Medicare Long-Term Care Hospital Improvement Act of 2006, H.R. 6236, 109th Cong. (2006).

[50] Letter from U.S. Senators to Dr. Mark McClellan, Adm'r, CMS (Apr. 11, 2006); Letter from Members of U.S. House of Representatives to Mike Leavitt, Sec'y, U.S. Dept. of Health & Human Servs. (Apr. 3, 2006). We understand that similar letters are being prepared in the 110th Congress.

[51] *See* Medicare Long-Term Care Hospital Improvement Act of 2007, H.R. 562, 110th Cong. (2007); Medicare Long-Term Care Hospital Improvement Act of 2007, S. 338, 110th Cong. (2007).

from well-designed studies (or other compelling clinical evidence) indicate that developing this criteria is *feasible, we would consider revisions to the HwH regulations.*"[52] With the four-year transition period set to expire next year, CMS has clearly failed to assess the feasibility of developing patient and facility criteria, notwithstanding that the agency has received data from well-designed studies, in fact, studies that CMS itself commissioned (i.e., RTI), demonstrating that developing criteria is feasible. CMS has reneged even on its own commitment to seriously examine the possibility of establishing patient and facility criteria.

In sum, in light of MedPAC's and RTI's recommendations and the emerging Congressional support for this proposition, we urge CMS to turn its attention to developing patient and facility criteria rather than expanding the 25 Percent Rule. Rather than expanding an arbitrary threshold[53] that has, at best, a tenuous connection with the problem CMS has identified, Medicare beneficiaries would be better served by implementation of patient and facility criteria that bear a clear relationship to the appropriateness of LTC hospital admissions.

b. *The proposed expansion of the 25 Percent Rule is arbitrary and unsupported by the evidence.*

As described above, the existing 25 Percent Rule was promulgated to reduce the number of inappropriate admissions to co-located LTC hospitals (i.e., medically unnecessary referrals from a host hospital to an LTC HwH to maximize Medicare reimbursement). Now, in the final year of the 25 Percent Rule's four-year phase-in, CMS is again seeking to remedy its concern that the Medicare program is, in the LTC hospital context, effectively making two payments for the same episode of care. However, the Proposed Rule does not provide any credible support for this assertion. CMS offers only vague assertions in support of its proposed extension of the 25 Percent Rule, such as being "aware anecdotally of the existence of 'arrangements' between Medicare acute and post-acute hospital-level providers that may not have any ties of ownership or governance relating to patient shifting that appear to be based on mutual financial gain rather than on significant medical benefits for the patient."[54] Such amorphous "anecdotal" evidence does not provide the meaningful opportunity for independent verification and comment by interested stakeholders that is required by the Administrative Procedure Act.[55] To fulfill this requirement, not only is an opportunity to comment required but also the opportunity to review the reasoning and data underlying a proposed rule.[56] While CMS does cite MedPAR data on LTC hospital admissions generally, the agency has not offered any concrete evidence of the existence of "arrangements" between non-co-located general acute care hospitals and LTC hospitals to manipulate the Medicare payment system. Thus, CMS has not fulfilled the APA requirement that interested parties receive a meaningful opportunity

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[52] 69 Fed. Reg. at 49,211-12 (emphasis added).

[53] The 25 percent threshold has no clinical basis. It was first suggested by a commenter to CMS's FY 1995 Proposed Rule that originally implemented the separateness criteria for HwHs. 59 Fed. Reg. at 45,390.

[54] 72 Fed. Reg. at 4,811.

[55] *See* 5 U.S.C.§ 553(c) (2006).

[56] *See, e.g., Home Box Office, Inc. v. FCC*, 567 F.2d 9, 35 (D.C. Cir. 1977) ("the notice required by the APA, or information subsequently supplied to the public, must disclose in detail the thinking that has animated the form of a proposed rule and the data upon which that rule is based"); *Portland Cement Association v. Ruckelshaus*, 486 F.2d 375, 394 (D.C. Cir. 1973) ("In order that rule-making proceedings ... be conducted in orderly fashion, information should generally be disclosed as to the basis of a proposed rule at the time of issuance").

to participate in the rulemaking process. The APA requires agencies to "develop an evidentiary basis for its findings . . . [and] examine the relevant data and articulate a satisfactory explanation for its action, including a 'rational connection between the *facts found* and the choice made.'"[57] Here, the agency has not found any facts and is basing significant policy changes that will affect millions of Medicare beneficiaries on mere "anecdotal" evidence. "Conclusory statements ... do not fulfill the agency's obligations."[58]

In the Proposed Rule, CMS cites MedPAR data indicating that "for over 50 percent of all freestanding LTC hospitals, at least 50 percent of their discharges were for patients admitted from an individual acute care hospital."[59] This data alone does not support CMS's conclusion that Medicare is paying twice for a single episode of care. Further, CMS does not reference data reflecting referral patterns for other provider types, whether acute care or post-acute care, to provide context as to whether this ratio is at, above, or below the average within the hospital industry. CMS also fails to establish a connection between these referral patterns and the existence of "arrangements" to engage in inappropriate patient shifting.

If Medicare was truly paying twice for the same episode of care, then the patients being discharged from the short-term acute care hospital and LTC hospital would be assigned the same DRG. MedPAR data, however, shows otherwise. There is very little overlap between the most common DRGs assigned to short-term and LTC hospital patients. LTC hospital patients experience different episodes of care in the short-term care hospital than in the LTC hospital, based upon different patient characteristics and courses of treatment. For example, the most common DRGs for patients discharged from a short-term care hospital to a LTC hospital are 541 and 542 (i.e., patients who have received tracheotomies and are also ventilator dependent). In 2005, there were 13,753 discharges from general acute care hospitals to LTC hospitals in these DRGs. However, only 1,212 patients were discharged from LTC hospitals with these DRG assignments. This demonstrates that patients are experiencing different episodes of care in the general acute care hospital and LTC hospital – thus, they are assigned different DRGs, reflective of a specific and different course of treatment provided in the LTC hospital.

MedPAR data from 2005 also show that the average LOS for general acute care hospital patients who are discharged to an LTC hospital is more than four days longer than the geometric mean LOS for *all* patients in the same DRGs.[60] This indicates that more medically complex patients typically sent to LTC hospitals are staying in the short-term acute care hospitals *longer* than the average patient. Thus, this data completely undermine CMS's contention that short-term acute care hospitals are systematically discharging patients to LTC hospitals in order to maximize their profits.

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[57] *Motor Vehicle Mfrs. Ass'n v. State Farm Mutual Automobile Ins. Co.*, 463 U.S. 29, 43 (June 24, 1983) (quoting *Burlington Truck Lines v. United States*, 371 U.S. 156, 168 (1962)) (emphasis added); *In re Sang-sue Lee*, 277 F.3d 1338, 1344 (Jan. 18, 2002).

[58] *In re Sang-su Lee*, 277 F. 3d at 1344.

[59] 72 Fed. Reg. at 4,812.

[60] The only exception to this pattern occurs with respect to DRGs 541 and 542 (i.e., patients dependent on a ventilator who also received a tracheotomy). Payment for nearly 70 percent of these patients is less than a full DRG amount because payment is adjusted by the post acute care transfer policy. *See* the discussion of the post acute care transfer policy below.

CMS also states in the Proposed Rule that "[it has] become aware of certain LTCH companies that have both established new LTCHs and/or are considering relocating existing HwHs or LTCH satellites so that they are at least 300 yards from the acute care hospital, thus side-stepping the intent of existing § 412.534."[61] However, the mere fact that new LTC hospitals may be located 300 yards from an acute care hospital does not imply that the two facilities are "gaming" the LTC hospital PPS. Here again, CMS cites no evidence of such "gaming" other than the bald assertion that these arrangements are suspect.

CMS relies in the Proposed Rule on a 2005 Lewin Group report commissioned by the National Association of Long Term Care Hospitals (NALTH) concerning patients admitted to LTC hospitals from a single source.[62] NALTH has emphasized, however, with respect to CMS's reliance on the report, that the report stated that the 25 Percent Rule is at "extreme variance with the demographics of how patients are referred to post-acute hospitals throughout the United States."[63] NALTH has requested that CMS correct the public record by fully reporting the Lewin Group's conclusion, including that the application of the 25 Percent Rule is an arbitrary threshold and ignores how post-acute care referrals in the hospital industry have evolved.[64] Further, CMS has not analyzed the underlying data that the Lewin Group used and has not made the report available to stakeholders to review its conclusions or analyze its methodologies. We urge CMS to make the full report available and perform a detailed analysis of its findings.

LifeCare recognizes CMS's concern regarding the potential for inappropriate LTC hospital admissions in certain business relationships between general acute care hospitals and LTC hospitals. As described above, we believe—and MedPAC and RTI agree—that adopting admissions criteria that are clinically based and do not rely solely on arbitrary admissions thresholds would be a far more effective method to curtail any such abuses.

c. *Expansion of the 25 Percent Rule would force LTC hospitals into an unsustainable financial position.*

Not only does the proposed expansion of the 25 Percent Rule fail to directly address the appropriateness of LTC hospital admissions, it would also force LTC hospitals into accepting payment terms that threaten their financial stability. CMS states that it is "unable to determine how significant the impact of some of the provisions of this proposed rule may be on small entities since [it] expect[s] many LTCHs to adjust their admission practices if some of these provisions are implemented."[65] Similarly, in its March 2007 report, MedPAC stated in discussing the impact of the current 25 Percent Rule that "[i]f HwHs do not change their behavior, the Medicare margin [for LTC hospitals] is estimated to be 0.1 percent. If they change behavior to avoid payment reductions, the margin is estimated to be 1.9 percent. There are a number of ways HwHs can change behavior to minimize the effect of the rule."[66] On their face, these statements demonstrate that CMS and

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[61] 72 Fed. Reg. at 4,812.

[62] *Id.* at 4,818.

[63] Letter from NALTH to Dr. Mark McClellan, Adm'r, CMS, at 24 (Mar. 13, 2006).

[64] *Id.* at 25.

[65] 72 Fed. Reg. at 4,832.

[66] MedPAC report, *supra* note 3, at 221.

MedPAC expect LTC hospitals to alter their admissions policies to minimize the impact of payment policy changes.

However, LTC hospitals, and, indeed, all Medicare-participating providers, do not have unbridled discretion to deny admission to Medicare beneficiaries or have separate admissions policies specific to Medicare beneficiaries. Specifically, the Medicare regulations state that CMS may terminate a provider's Medicare participation agreement where the provider "places restrictions on the persons it will accept for treatment and it fails either to exempt Medicare beneficiaries from those restrictions or to apply them to Medicare beneficiaries the same as to all other persons seeking care."[67] Thus, a Medicare provider may not refuse admission to Medicare patients unless the provider also refuses admission to similarly situated non-Medicare patients. CMS has confirmed this restriction in various pronouncements and rulings.[68] LTC hospitals, therefore, cannot refuse to admit Medicare patients on the basis of payment inadequacy. At the same time, if the 25 Percent Rule is expanded as proposed, LTC hospitals must accept the lower Medicare payments levels that apply after the LTC hospital reaches the 25 percent threshold for admissions from any general acute care hospital. As such, CMS effectively is incenting LTC hospitals to make admissions decisions based on considerations other than medical appropriateness.

CMS is placing LTC hospitals in the untenable position of having to accept sicker, more medically complex Medicare patients but, after admissions exceed the 25 percent threshold, being unable to receive payments sufficient to offset the high costs of treating these severely ill patients. Thus, the proposed expansion of the 25 Percent Rule would threaten the financial viability of these hospitals and their ability to continue providing Medicare beneficiaries with the specialized care they require.

d. *The proposed expansion of the 25 Percent Rule ignores fundamental principles of PPS.*

The basic premise of a prospective payment system recognizes that Medicare pays hospitals in "an amount per discharge based on the *average* costs of delivering care for that diagnosis...."[69] The Proposed Rule would violate this premise by removing a significant number of cases from the standard LTC hospital PPS formula and reimbursing them at a level appropriate only for general acute care hospitals. In so doing, CMS's proposal would also contravene its historical pronouncements regarding LTC hospital PPS payments as well as Congress's basis for first excluding LTC hospitals from PPS and then establishing a separate PPS—that the general IPPS rates are inadequate to reimburse LTC hospitals for the care they provide.

Specifically, as described above, Congress in 1983 acknowledged that the "DRG system was developed for short-term acute care general hospitals and as currently constructed does not

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[67] 42 C.F.R. § 489.53(a)(2).

[68] *See, e.g.*, 58 Fed. Reg. 46,270 (Sept. 1, 1993) ("[A] hospital may not refuse to provide a covered service to a Medicare beneficiary if it provides that service to other patients"); 60 Fed. Reg. 45,778, 45,789 (Sept. 1, 1995); 59 Fed. Reg. 45,330, 45,343 (Sept. 1, 1994); *see also* Termination Of Provider's Agreement -- Withholding A Segment Of Services From Title XVIII Medicare Patients, HCFA Ruling No. 78-19 ("[n]o Medicare patient may have withheld from him services ordinarily provided by the health care institution to its patients generally if the institution is to qualify or remain qualified as a provider of services").

[69] 71 Fed. Reg. 4,647, at 4,693 (Jan. 27, 2006) (emphasis added).

adequately take into account special circumstances of diagnoses requiring long stays."[70] Congress reiterated this concern about the "special circumstances" of LTC hospitals when it directed CMS to develop an LTC hospital-specific PPS in the BBRA and BIPA, and CMS itself expressly recognized in the Final Rule implementing the LTC hospital PPS that these hospitals "would be systemically underpaid if the [IPPS] DRG system were applied to them."[71] Yet, CMS is proposing a policy change that is clearly at odds with this historic treatment of LTC hospitals within the Medicare Program and the clear Congressional mandate to afford LTC hospitals protected status.

Thus, although LTC hospitals accept more medically complex and costly patients, once a facility reaches the 25 percent threshold for any referring acute care hospital, it will be unable to receive the appropriately higher payments that are necessary to provide equitable reimbursement. Over time, these payment shortfalls will move LTC hospitals further and further away from the PPS goal of providing payment based on the average costs of providing care and contravene the Congressional directive to provide payment to LTC hospitals that recognize the "special circumstances" of these institutions.

e. *The proposed expansion of the 25 Percent Rule to "grandfathered" HwHs violates Congressional intent and is not supported by the evidence.*

As with CMS's proposed expansion of the 25 Percent Rule to all subclause (I) LTC hospitals, CMS has offered no evidence to support an expansion of the 25 Percent Rule to grandfathered HwHs. CMS states that it does not "believe that it is reasonable to assume that by creating a limited exception for these hospitals, Congress was immunizing these facilities from any further regulation by the Secretary as to their growth and financial impact on the Medicare program."[72] We disagree with CMS that Congress did not intend to create a protected class of provider. As described above, in enacting Section 4417 of the BBA, Congress gave this small group of HwHs special status in the Medicare payment system by excepting them from application of the separateness and control criteria, and CMS at the time promulgated regulations that implemented this Congressional directive. In the BBA conference report, Congress stated that the reason for the statutory changes was because "[c]ertain hospitals that have provided quality care to Medicare beneficiaries are in jeopardy because of ... [CMS] regulations which would make them no longer eligible to qualify as long-term care hospitals. This [legislative] provision would ensure that they would continue to qualify as [an LTC hospital] as long as they maintained an average length of stay of 25 days and other Medicare certification requirements."[73] Later, when CMS promulgated the 25 Percent Rule, it exempted these grandfathered HwHs from application of the Rule by determining that the Rule applied only to hospitals meeting the separateness and control criteria.[74] The agency did so in full recognition of these hospitals' special Congressionally conferred status and historic treatment.

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[70] H.R. Rep. No. 98025, at 141 (1983).

[71] 67 Fed. Reg. at 55,957.

[72] 72 Fed. Reg. at 4,813-14.

[73] H.R. Rep. No. 105-149, at 1339 (1997) (Conf. Rep.).

[74] 42 C.F.R. § 412.534(a).

Since 1994, CMS has repeatedly maintained that the HwH rules do not apply to grandfathered LTC hospital HwHs. Significantly, in the Final Rule for the FY 2003 IPPS update, CMS stated that:

> The intent of the grandfathering provision was to ensure that hospitals that had been in existence prior to the effective date of our hospital-within-hospital requirements *should not be adversely affected by those requirements*. To the extent hospitals were already operating as hospitals-within-hospitals without meeting those requirements, we believe it is appropriate to limit the grandfathering provision to those hospitals that continue to operate in the same manner as they had operated prior to the effective date of those rules.[75]

CMS has also stated that "in establishing grandfathering provisions, our general intent has been to protect existing hospitals from the potentially adverse impact of recent, more specific regulations that [the agency] now believe[s] to be essential... ."[76] Thus, CMS itself has affirmed the principle that grandfathered hospitals should not be subject to the HwH rules (including the 25 Percent Rule) and that the purpose of grandfathered status is to protect certain HwHs from any new requirements that would result in an "adverse impact" on these hospitals.

Significantly, CMS has not provided a rational basis for altering the protected status of these LTC providers. It is noteworthy that the agency's rationale for the original 25 Percent Rule -- concern about the growth in the number of LTC hospitals in recent years -- has no applicability to grandfathered LTC HwHs, which, by definition, cannot grow in number.

In sum, throughout the implementation of the LTC hospital PPS and the adoption of the current 25 Percent Rule, CMS has expressly recognized the special status that Congress granted grandfathered LTC hospitals, and grandfathered LTC hospitals have long relied on CMS's statements that the HwH rules, including the 25 Percent Rule, do not apply to them. Applying the 25 Percent Rule to grandfathered HwHs at this time would upset the well-settled expectations of these facilities, threaten their financial viability, and violate Congressional intent.

f. *The proposed expansion of the 25 Percent Rule is premature.*

In proposing to expand the 25 Percent Rule, CMS is acting without allowing sufficient time to study and collect data on the impact of the existing 25 Percent Rule. In particular, the current 25 Percent Rule is designed to address many of the concerns regarding inappropriate LTC hospital admissions in the specific setting where CMS believes they are prone to be generated. As noted above, this change, initiated in FY 2005, was to be phased in over four years.[77] Because the existing 25 Percent Rule has not been fully implemented, CMS does not yet have sufficient data to evaluate whether the Rule is already achieving CMS's policy goals.

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[75] 68 Fed. Reg. 45,346, 45,463 (Aug. 1, 2003) (emphasis added).

[76] *Id.*

[77] 69 Fed. Reg. at 49,251-52.

In fact, CMS, in its discussion in the Proposed Rule of the one-time budget neutrality adjustment, has acknowledged the value of gathering sufficient data to conduct a thorough evaluation before making important policy decisions. In discussing its decision to delay making this adjustment, CMS states that "we believe that postponing the deadline... would result in the availability of additional data... and, therefore, our decisions regarding a possible adjustment would be based on more complete and up-to-date data."[78] This statement acknowledging the need to gather and evaluate sufficient data before making a decision on the one-time budget neutrality adjustment is wholly inconsistent with CMS's proposal to implement a much more radical change—expansion of the 25 Percent Rule—before there is time to evaluate the effects of the fully implemented existing Rule. At a minimum, therefore, the agency should delay implementing the proposed expansion of the 25 Percent Rule until credible, statistically valid data is available to evaluate the impact of the current Rule.

Further, in the Proposed Rule, CMS states that it is still reviewing some of the RTI recommendations, including the feasibility of developing patient and facility level criteria.[79] CMS has also noted that RTI has formed a "technical expert panel" to further develop some of its recommendations. Thus, based on CMS's own admission, it should not make significant policy changes such as those proposed here until the agency has had a full opportunity to review and process all of the RTI recommendations.

Finally, CMS should postpone any additional significant policy changes until the effects of full implementation of the LTC hospital PPS are well understood. As the agency is aware, the LTC hospital PPS was implemented over a five-year period. LTC hospitals are in the first year of full LTC hospital PPS implementation. CMS has already made significant policy and payment changes to the LTC payment system during this phase-in period. The agency should hold off from implementing additional changes at this time that would inject further instability into the LTC hospital PPS.

g. *Existing CMS policies already address concerns about patient shifting.*

Medicare regulations have already been implemented to discourage inappropriate patient shifting between providers. For example, under the post acute care transfer policy, general acute care hospitals are reimbursed below the full DRG payment when a patient's length of stay is shorter than the geometric mean length of stay for the DRG whenever patients in selected DRGs are discharged to other providers, including LTC hospitals. Significantly, 85 percent of DRGs applicable to short-term acute care hospital discharges to LTC hospitals are subject to this policy. The post acute care transfer policy was created because of the same concerns CMS has articulated in the Proposed Rule, i.e., that the general acute care hospital is discharging patients too early, resulting in two payments for one episode of care. In the Proposed Rule, CMS concedes that "[i]n the case of the post acute transfer policy . . . we focused on overpayment . . . to the transferring hospital when a patient is prematurely discharged to another provider during the same episode of

[78] 72 Fed. Reg. at 4,803.

[79] 72 Fed. Reg. at 4,818.

illness."[80] In enacting this policy, Congress even stated that it was concerned about Medicare "pay[ing] twice for these [same] services provided in different settings."[81]

Thus, the 25 Percent Rule should not be expanded because it is clearly duplicative of existing Medicare policies.

h. *Potential alternatives.*

Although we strongly believe that it is inappropriate to expand the 25 Percent Rule to all subclause I LTC hospitals, if CMS insists on finalizing this proposal, we urge the agency to, at a minimum, provide a four-year phase-in period analogous to the transition period that was afforded to co-located HwHs in connection with implementation of the current 25 Percent Rule. In implementing that transition period, CMS noted that "[t]ransitions are a frequently incorporated feature of new Medicare payment policies."[82] There is no basis to treat other LTC hospitals, particularly grandfathered LTC HwHs, any differently in this regard.

Second, similar to the grandfathered protective status that CMS afforded existing LTC HwHs and those that were under development when it originally implemented the 25 Percent Rule, should CMS finalize its proposal to expand the Rule, the agency should also grandfather any existing subclause I LTC hospitals that are not subject to the current Rule, as well as those facilities that are under development.

2. Short Stay Outlier (SSO) Cases

As noted above, CMS is proposing to generally reduce LTC hospital payments to the IPPS rate for SSO cases where the covered LOS is equal to or less than the IPPS comparable threshold—the average length of stay plus one standard deviation for the same DRG at short-term acute care hospitals.[83]

a. *CMS incorrectly assumes that SSO patients do not need LTC hospital care.*

As justification for this revision to the SSO payment methodology, CMS cites concerns similar to those it expressed in support of the RY 2007 revision to the SSO policy and the proposed extension of the 25 Percent Rule—namely, its "belief that many LTC hospitals appear to be admitting some SSO patients that could have received the care at the acute care hospital."[84] As discussed above, this "belief" is wholly unsubstantiated.

As support for its revised payment methodology for SSO cases where a patient's covered LOS at the LTC hospital is less than or equal to the IPPS comparable threshold, CMS cites its determination, based on FY 2005 MedPAR data, that 42 percent of LTC hospital SSO discharges

[80] 72 Fed Reg. at 4,811.

[81] H.R. Rep. No. 105-149, at 1334 (1997) (Conf. Rep.).

[82] 69 Fed. Reg. at 49,206.

[83] 72 Fed. Reg. at 4,806-07.

[84] 72 Fed. Reg. at 4,806.

had lengths of stay less than or equal to the IPPS comparable threshold.[85] According to CMS, the cases comprising this 42 percent of LTC hospital SSO cases "appear to be comparable to typical stays at acute care hospitals." CMS then concludes that it is "overpaying" for these SSO cases.[86] However, in drawing this conclusion, CMS does not explain why it believes that it is "appropriate to compare the covered LOS of a LTCH case grouped to a particular LTC-DRG to the ALOS plus one standard deviation for the corresponding DRG under the IPPS."[87] Neither does CMS take into account the reality that LTC hospital patients are medically more complex than patients in general acute care hospitals. Even short stay LTC hospital patients are sicker and present with more comorbidities than comparable patients in short-term acute care hospitals. Significantly, Medicare data show that short stay LTC hospital patients have stays that are much longer than the average general acute care hospital patient with the same diagnosis. These differences in lengths of stay reflect the complexities associated with treating LTC hospital patients—complexities that are present even if the patient's stay is shorter than the IPPS comparable threshold. This difference in complexity is further demonstrated by examining the lengths of stay of patients in general acute care hospitals that are transferred to a LTC hospital. These LOS data reveal that, in general, transfer patients have a LOS in general acute care hospitals that exceeds the geometric mean LOS for their DRGs.

b. *LTC hospitals cannot predict a patient's length of stay.*

In addition to its inappropriate comparison between patients admitted to LTC hospitals and those admitted to general acute care hospitals, CMS also draws a specious connection between discharges from general acute care hospitals and improper admissions of "SSO patients that could have received the care at the acute care hospital." According to CMS, "[w]e believe that when these patients are admitted to a LTC hospital for an extremely short stay, the LTC hospital appears to be serving as a step-down unit of the acute care hospital."[88] However, CMS does not cite any evidence of general acute care hospitals systematically discharging patients early to maximize reimbursements. Indeed, CMS's proposed revision to the SSO payment methodology appears to rest on the incorrect assumption that LTC hospitals can somehow predict a patient's length of stay. CMS fails to recognize the clinical reality that, when a patient is admitted to a LTC hospital, the patient does not present with discernable characteristics indicating whether he or she will be a short stay patient or have a "normal" length of stay. CMS's policy also does not acknowledge that some patients will expire shortly after admission to a LTC hospital. LTC hospitals must make their admissions decisions on the basis of the patient's medical condition at the time he or she presents for admission—not on speculation that the patient will be a SSO. Moreover, many LTC hospital admissions are referred from other providers based on the medical judgment of the referring physician.

Further, based on a review of 2004 MedPAR data, the proportion of SSO patients who present with diagnoses with the highest severity of illness and risk of mortality scores is consistent with that presented by longer stay patients within the same DRGs. In DRG 475, for example, approximately 93 percent of SSOs present an APR-DRG severity score of three or four. The

[85] 72 Fed. Reg. at 4,805.

[86] 72 Fed. Reg. at 4,806.

[87] 72 Fed. Reg. at 4,805.

[88] 72 Fed. Reg. at 4,806.

severity scores for non-SSO patients within this DRG are virtually the same, with 94 percent presenting with severity scores of three or four. The severity scores associated with other DRGs lead to the same conclusion – that, at the time of admission, the likelihood that a particular patient will be an SSO patient cannot be predicted based on severity of illness scores.

Thus, it is clear that LTC hospitals cannot predict the expected length of stay in a LTC hospital based on the information available at admission. Instead, LTC hospitals make these decisions based on a clinical evaluation of medical need. Currently, most LTC hospitals use tools such as the InterQual® Long-Term Acute Care Criteria to assess the appropriateness of a patient's admission, continued stay, and ultimate discharge. The InterQual® criteria are among those MedPAC has recommended using to define more precisely the level of care provided by LTC hospitals.[89] Many of Medicare's QIOs use similar criteria to evaluate LTC hospital admissions. LifeCare also uses the InterQual® criteria to guide its admissions decisions. A recent review of the QIO activity in seven of our hospitals revealed a statistically insignificant number of denials.

Nonetheless, CMS proposes to reduce payments to the IPPS rate for SSO cases where the covered LOS is equal to or less than the IPPS comparable threshold. We recognize CMS's concern that some short stay patients may not have been appropriately admitted to LTC facilities and therefore should not receive full LTC-DRG payments. However, there is simply no support for the assumption that short stay patients at LTC hospitals generally do not require the same level of service as longer stay patients. As noted above, a more effective method for ensuring proper LTC hospital admissions would be to adopt admissions criteria that would allow only for admissions of patients who are medically complex and in need of the services provided by LTC hospitals.

c. *The proposed revision to the SSO payment methodology is premature.*

According to CMS, "[it] continue[s] to be concerned about appropriate payment for SSO cases under the LTCH PPS, and therefore, [is] considering a policy change for the purpose of differentiating between those SSO cases that we believe are more appropriately admitted and treated at LTCHs as distinguished from those with a LOS that resemble cases typically treated at acute care hospitals."[90] However, as with the proposed expansion of the 25 Percent Rule, CMS is acting without allowing sufficient time to study and collect data on the impact of the current SSO payment methodology. It is especially important to conduct a thorough evaluation of the most recent changes to the SSO payment methodology because these changes were implemented to address the very same concerns over inappropriate LTC hospital admissions that CMS is now expressing.[91] Given that the current methodology was finalized less than one year ago, neither CMS nor the LTC hospital industry has had adequate time to evaluate whether CMS's concerns over inappropriate admissions have already been remedied by the current SSO payment methodology. We therefore urge CMS, as with the proposed extension of the 25 Percent Rule, to, at a minimum, withdraw the Proposed Rule provisions relating to the SSO payment methodology and allow time for all interested parties to examine relevant SSO data and determine whether additional changes are necessary to address inappropriate LTC hospital admissions.

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[89] *See* 2004 MedPAC Report, *supra* note 42, at 121-34.

[90] 72 Fed. Reg. 4,807.

[91] 71 Fed. Reg. at 27,878-79.

d. *CMS should propose specific regulatory language before it finalizes changes in its SSO policies.*

The Administrative Procedure Act provides that a notice of proposed rulemaking should include the "*terms* or substance of the proposed rule."[92] In this Proposed Rule, CMS has failed to meet this requirement because it has only described a general approach to revising the SSO policy, but has not provided any specific regulatory language that would be subject to public comment. Case law has held that general requests for comments constitute inadequate notice of proposed regulatory changes.[93] In this Proposed Rule, CMS states that "[w]e are interested in soliciting comments on this approach as well as suggestions as to alternative ways in which to address our concerns."[94] Thus, by CMS's own admission, the agency is interested in considering alternative approaches to its concerns and is not yet prepared to finalize any one policy that could be subjected to public comment. CMS should promulgate such a specific regulation before it finalizes any changes to the SSO policy.

B. Comment: "Proposed Changes to LTCH PPS Payment Rates for the 2008 LTCH PPS Rate Year"

1. The market basket update should be 3.2 percent, the most recent market basket estimate for FY 2008.

In the Proposed Rule, CMS proposes a market basket update of 0.71 percent—2.49 percent lower than the most recent market basket estimate of 3.2 percent. CMS asserts that this 2.49 percent reduction is an "an adjustment to account for the increase in case-mix in the prior period (FY 2005) that resulted from changes in coding practices rather than an increase in patient severity."[95] However, the 0.71 percent update is neither adequate to reimburse the actual cost increases experienced by LTC hospitals nor supported by relevant data. Combined with other payment adjustments proposed by CMS, a 0.71 percent market basket update would result in reimbursement below LTC hospitals' cost of care. Further, CMS's assertion that a reduction in the market basket update is appropriate to account for a case-mix increase resulting from changes in coding practices is not supported by the facts.[96] To date, CMS has provided no data to support its belief that some portion of the case-mix increase between FY 2004 and FY 2005 was due to anything other than real changes in patient severity.[97] CMS has also failed to justify its use of the 1.0 percent increase in real case-mix under the IPPS as a proxy for the case-mix increase under the LTC hospital PPS.[98] Absent such data, CMS's determination that 0.71 percent is the appropriate update amount is simply not credible.

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[92] 5 U.S.C. § 553(b) (emphasis added).

[93] *See United Church Board of World Ministries v. SEC*, 617 F. Supp. 837, 840 (D. D.C. 1985) (stating that "[a] general request for comments is not adequate notice of a proposed rule change").

[94] 72 Fed. Reg. at 4,808.

[95] *Id.* at 4,790.

[96] In fact, CMS has commented that "changes in the LTCH coding practices ... appear to be stabilizing as LTCHs become more familiar with a DRG-based system." 72 Fed. Reg. at 4,785.

[97] *See* 72 Fed. Reg. at 4,791.

[98] *See id.* at 4,792.

In addition, in its discussion of the appropriateness of implementing a budget neutrality requirement for the annual LTC-DRG update, CMS states that "the most recent such LTCH claims data primarily reflects changes in the resources needed by an average LTCH case in a particular LTC-DRG (and not changes in coding practices). Thus, we now believe it would be reasonable and appropriate to update the LTC-DRGs in a budget neutral manner, beginning in FY 2008, so that estimated aggregate payments under the LTCH PPS would be unaffected."[99] CMS's acknowledgment that the most recent LTC hospital claims data do not reflect changes in coding practices for purposes of determining whether to implement a budget neutrality requirement is inconsistent with its reliance on changes in coding practices to reduce the market basket update. Given that a 0.71 percent update would result in payment rates below the cost of care and therefore may imperil access to the service provided by LTC hospitals, CMS should give considerable weight to its own conclusion that changes in coding practices are not a significant factor contributing to changes in the claims data. We therefore strongly recommend setting the market basket update for RY 2008 at 3.2 percent.

2. One-Time Budget Neutrality Adjustment

With respect to the potential one-time budget neutrality adjustment to ensure 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 for future years,"[100] CMS states that it is not proposing to make this adjustment at this time.[101] We agree that this one-time adjustment is unnecessary at present and, moreover, strongly believe that CMS should not make this adjustment at any time. Given that CMS, as described above, implemented a number of Medicare payment reductions since the first year of the LTCH hospital PPS and is now proposing changes that would further reduce payments to LTC hospitals, any "significant difference between actual payments and estimated payments" in the first year of the LTC hospital PPS surely would have been offset by this time. Therefore, it should not be necessary for CMS to ever make this adjustment.

C. Comment: "LTC-DRG Classifications and Relative Weights"

CMS proposes to impose a budget neutrality requirement for the annual LTC-DRG reweighting such that, beginning with the LTC-DRG update for FY 2008, estimated aggregate LTC hospital PPS payments will be unaffected.[102] LifeCare agrees that such a budget neutrality requirement is appropriate because it is consistent with CMS's budget neutrality policy with regard to IPPS DRG reweighting.[103] However, CMS should continue to monitor the annual reweighting of LTC-DRGs to ensure that it does not result in the redistribution of payments from high acuity DRGs to lower acuity DRGs, pending implementation of revised certification criteria designed to screen out inappropriate cases.

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[99] *See id.* at 4,786.

[100] *Id.* at 4,802.

[101] *Id.* at 4,804.

[102] *Id.* at 4,845.

[103] This requirement is also included in the current House and Senate legislation discussed above.

V. CONCLUSION

We appreciate the opportunity to comment on the important issues raised by the Proposed Rule and urge you to address our concerns in a manner that fully protects Medicare beneficiaries' access to medically necessary LTC hospital services for complex conditions. We request that CMS carefully consider the recommendations offered above in determining appropriate Medicare payment levels for LTC hospitals. Please contact us if we can provide you with any additional information or assistance.

Sincerely,

/s

Jill L. Force
Executive Vice-President
LifeCare Holdings, Inc.

Submitter : Mr. Steven Kowske **Date:** 03/26/2007

Organization : Aurora Health Care

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1529-P-133-Attach-1.DOC

Submitter : Mr. David buckley **Date:** 03/26/2007

Organization : St. John Health

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Submitter : **Mrs. Lisa Stone** **Date: 03/26/2007**

Organization : **Long Term Hospital of Tuscaloosa**

Category : **Long-term Care**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1529-P-135-Attach-1.PDF

#135

Long Term Hospital of Tuscaloosa
809 University Blvd 4th Floor
Tuscaloosa, Al 35401

March 26, 2007

BY ELECTRONIC FILING

Hon. Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1529-P
Mail Stop C4-26-5
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: ***Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes; Proposed Rule, 72 Fed. Reg. 4776 (February 1, 2007)***

Dear Ms. Norwalk:

This letter presents comments and recommendations of Long Term Hospital of Tuscaloosa, ("LTHT") to certain aspects of the proposed annual payment rate updates and policy changes under the prospective payment system for long-term acute care hospitals ("LTACH PPS") for rate year ("RY") 2008, which were published by the Centers for Medicare & Medicaid Services ("CMS") on February 1, 2007.

LTHT is a not-for-profit hospital in Tuscaloosa, Al. We are a 27 bed hospital within a hospital (HIH) and the closest Long Term Acute Hospital within a 70 mile radius for many of our patients in Alabama and Mississippi. We have 85 employees who have cared for 247 patients over the last year. We provide a specialized level of care for many of our patients especially patients requiring ventilatory support and we are concerned with the proposed changes. LTHT supports the comments made by ALTHA in their letter of March 23.

LTHT opposes the arbitrary and inappropriate reductions in long-term care hospital ("LTACH") payments that will result if these proposed changes to the LTACH PPS are implemented. LTHT has reviewed the proposed rule and agrees with ALTHA that it suffers from a number of recurring problems. First, as with other recent rulemakings affecting LTACHs, CMS continues to rely upon materially flawed and incomplete data in developing their proposed changes to LTACH payments for RY 2008. Second, LTHT does not believe that CMS has seriously considered the legal and equitable issues which this proposed rule raises with regard to patient freedom of choice, physician medical decision-making, and the disparate impact on LTACHs in underserved areas.

LTHT recommends that CMS reconsider its proposed changes to the LTACH PPS in light of the Medicare Payment Advisory Commission ("MedPAC") recommendations in June 2004 that the certification criteria for the Medicare LTACH provider category be strengthened to ensure that LTACH payments are being made to only those providers that are administering medically complex care to severely ill patients. LTHT supports this approach as a more defined method for limiting LTACH payments to hospitals that are truly caring for a medically complex patient population. Unfortunately, the proposals that CMS advances in this proposed rule continue to rely on arbitrary and unproven payment reductions to achieve policy goals that are, in many cases, compatible with more comprehensive LTACH certification criteria but will not achieve those goals and will significantly hinder the ability of our LTCH's to continue to provide quality patient care to Medicare beneficiaries.

LTHT strongly believes that arbitrary payment reductions are the wrong approach if quality of care is to be encouraged.

First and foremost, CMS should reconsider its proposed policy for extending the so-called "25% rule" from hospitals-within-hospitals ("HIH's") to all LTACH's, and its proposed policy to enlarge the category of short-stay outlier ("SSO") cases. To the extent that CMS is concerned about "inappropriate" admissions to LTACH's, it should implement more appropriate non-payment approaches such as pre-admission physician certifications, uniform admission screening criteria, and more extensive Quality Improvement Organization ("QIO") reviews. 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, LTHT supports that goal. 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. Moreover, the cumulative effect of these policies will result in significantly reduced and even negative operating margins in our not-for-profit LTACH's. Establishing payment policies that reimburse Medicare providers below the cost of care violates a basic premise of the Medicare program.

The proposed rule takes the next step in a series of apparently calculated efforts by CMS to reverse the growth in the number of LTACH's and reduce reimbursement to LTACH's for caring for Medicare beneficiaries suffering from complex medical conditions that require long hospital stays. In continuing to reduce payment rates and expose additional LTACH cases to payment rates for short-term acute care hospitals ("STACH's"), CMS fails to account for prior adjustments to the LTACH PPS in the past few years that have had a great deal to due with the lack of growth of new LTACH's in Alabama. CMS's own data shows that growth in the number of LTACH's has stopped. According to the December 2006 CMS Provider of Service file, there was a net reduction of one LTACH in 2006. With regard to margins, MedPAC estimated LTACH margins to be at or near zero even before the proposed rule was released. A comprehensive analysis of the proposed rule reveals that LTACH margins will be between negative 3.7% and negative 5.7% if the proposed policies are finalized. This reduction in payment significantly below the cost of providing care will dramatically impact the ability of all LTCH's, as well as LTHT's, to provide quality services to Medicare beneficiaries. CMS should not engage in this type of punitive rulemaking when Congress has provided express statutory authority for LTACH's and a PPS that reasonably reimburses LTACH's for the cost of care.

In the preamble to the proposed rule, CMS offers one primary justification in support of its two most significant policy proposals to extend the so-called "25% rule" from HIH's to all LTACH's and to enlarge the category of SSO cases: its belief that LTACH's are acting like units of STACH's, such that it believes that patients admitted to LTACH's are continuing the same episode of care that began during the patient's stay in the referring STACH. However, CMS fails to provide credible evidence that these interrelated issues are, in fact, occurring. CMS's own independent consultant, RTI International, has stated that the issue of LTACH's offering a continuation of a single episode of care is "poorly understood." The *opposite* is true – STACH's are not discharging patients to our LTACH's "early" and Medicare is *not* paying twice for a single episode of care. CMS's own data shows that LTACH patients have different characteristics than are evident during their preceding stay in a STACH. The data also shows that LTACH patients receive different treatments to address different clinical needs following a

stay in a STACH. Furthermore, differences in the medical complexity and average length of stay of LTACH cases substantiate reimbursement at the LTACH PPS rate, not the inpatient PPS rate for STACH's. CMS also has not presented evidence that LTACH's are acting like units of general acute care hospitals. The existence of primary referral and discharge relationships between our LTACH's and STACH's are both required by law and necessary to facilitate quality patient care in the most appropriate patient care setting.

LTHT has serious concerns about a number of unintended consequences associated with CMS's proposal to expand the 25% rule to freestanding LTACH's and grandfathered LTACH HIH's and satellite facilities. CMS is proposing to expand the existing payment limitation threshold to any LTACH or satellite of an LTACH that discharges during a single cost reporting period more than 25% (or applicable percentage for rural, single-urban, or MSA-dominant hospitals) of Medicare patients admitted from any non-co-located individual hospital. The original 25% rule was adopted by CMS in regulations that were recently published on August 11, 2004 and have yet to be fully implemented. Until the existing 25% rule is fully implemented, it is impossible to know the full impact of the existing rule on LTACH's and the impact that rule is having on patient access and quality of care for Medicare beneficiaries. What we do know is that the existing 25% rule, in combination with CMS's other payment policies has reduced growth in the net number of new LTACH's to negative numbers. Yet CMS is advancing a policy that, without question, will further restrict patient choice and diminish access to quality care by imposing a rigid, arbitrary, and extremely limiting quota on the number patients who will be fairly reimbursed at the LTACH PPS rates.

Further, limitations on the number of patients admitted from a single hospital severely undermine physician judgment to determine what clinical setting is in the best interest of the patient. Through its other policies, CMS has repeatedly reinforced a patient's right to choose a health care provider. But this proposed policy will have a discriminatory impact on LTACH's and Medicare beneficiaries. For no clinical reason, patients in the 26th percentile and higher will be paid like general acute care patients when their complex medical needs and relatively long stays require LTACH care. The LTACH's that we operate that are located in underserved areas or communities with less than four general acute care hospitals where LTACH's lack the ability to offset reduced patient referrals from one hospital with a greater number of LTACH-level patients from other hospitals will be extremely negatively impacted by this rule. These results have nothing to do with the care required by a particular patient or the quality of care offered by a particular LTACH, and has everything to do with the unintended consequences that will result from the arbitrary nature of establishing a payment limitation that has no relevance to patient or facility level criteria. For these reasons, the proposed rule not only penalizes us and other LTACH providers, it penalizes all Medicare beneficiaries.

LTHT is concerned that CMS has set forth yet another proposal to expand the class of SSOs that would effectively be paid at STACH rates without understanding the types of patients that would be treated as SSOs under the proposed policy. In the proposed rule, CMS indicates that it is considering lowering LTACH payment to the IPPS rate for cases with a length of stay that is less than the average length of stay plus one standard deviation for the same DRG under IPPS. Cases with a covered length of stay less than or equal to one standard deviation for the same DRG under IPPS would be paid at an amount comparable to the IPPS per diem.

As noted above, CMS offers the same justification for this short stay policy as is offered for the 25% rule policy. CMS believes that LTACH patients with "very short" lengths of stay have not completed their "episode of care" and should not have left the STACH. CMS's own data provides no support for this "belief." Moreover, rather than capture truly short-stay patients with lengths of stay that approximate STACH patient lengths of stay, as suggested, this policy would actually have the perverse effect of treating as SSOs many LTACH patients with lengths of stay that approach the 25-day average for LTACH certification (*e.g.*, 21 days, 23 days). LTHT strongly encourages CMS not to make further changes in the SSO policy based upon the data provided herein and because MedPAR data is not available yet to evaluate whether the SSO policy changes put into effect last year are achieving the

desired policy goals. CMS has produced no study or analysis in the proposed rule showing that inappropriate admissions constitute a material portion of SSO cases. To the contrary, the opposite is true: SSO cases are, in fact, appropriate for admission to LTACH's for a number of reasons, including the fact that even shorter stay LTACH's patients are more severely ill than comparable STACH patients; difficulty in screening SSOs from admission to LTACH's based upon clinical criteria at the time of discharge from the referring hospital; the inability of clinicians to predict when LTACH patients will expire; and the inherent averaging of patient lengths of stay that is the foundation of the current LTACH certification criteria and PPS. If the patient meets InterQual admission criteria, and can be reasonable expected to stay for an extended period of time, and a physician admits the patient, the LTCH should not be so severely financially penalized that negative operating margins are created. 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. It would seem that CMS would be aware that the rate of payment for these cases will be insufficient to cover LTHT's and other LTCH's reasonable and necessary costs in providing care to this segment of LTACH patients.

The proposed policies violate the statutory requirement that CMS reimburse LTACH's on a per discharge basis that reflects the reasonable and necessary cost of providing services in a hospital having an *average* length of stay of greater than 25 days. The proposed policies will continue to erode the LTACH PPS by reimbursing LTACH's for fewer and fewer medically complex patients at the LTACH PPS rates. The LTACH PPS must adequately reimburse LTACH's for the costs they incur in caring for Medicare beneficiaries. The cumulative effect of the proposed changes to the LTACH PPS will be to bring LTACH reimbursement below the cost of care. This level of reimbursement is unsustainable and will inevitably result in a decrease in access to LTACH services in spite of the increasing number of Medicare beneficiaries and the overall aging of the country's population. The Congress, the LTACH industry, MedPAC, and RTI International all agree that LTACH's serve an important role in caring for medically complex patients who need long-term hospital stays. CMS should develop policies that reflect this consensus. We encourage CMS to work with the Congress to develop meaningful facility and patient certification criteria for LTACH's, as proposed in H.R. 562 and S. 338.

LTHT objects to CMS's proposal to provide less than the full market basket update of 3.2% for RY 2008. An increase of less than the market basket will not account for the cost of goods and services required to deliver LTACH services and will result in rates below the cost of care. The full market basket update is an accurate reflection of items and services purchased to treat Medicare beneficiaries and is necessary to account for the rising cost of inputs. The federal rate must be updated in accordance with the market basket to keep LTACH payment rates in step with the higher cost of price inputs.

In summary, LTHT urges CMS to carefully consider the comments and data provided in this letter and to reexamine the policies advanced in the proposed rule. The types of patients admitted to LTACH's, the care provided during an LTACH stay, and the relationships that LTACH's have with STACH's show that Medicare is not paying twice for a single episode of care. LTACH's serve a distinct and important purpose in the health care continuum. LTHT provides a vital service, of meeting unmet healthcare needs for an underserved population in Alabama. CMS's payment policies should reflect this in a manner that fairly compensates LTACH's for the care they provide to thousands of Medicare beneficiaries in Alabama and across the nation.

Sincerely,

Lisa S Stone

Lisa Stone
Acting Administrator

Long Term Hospital of Tuscaloosa

Submitter : **Ms. Renee Zerehi** **Date: 03/26/2007**

Organization : **American College of Physicians**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1529-P-136-Attach-1.DOC

#136

ACP
AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE | *Doctors for Adults*

March 26, 2007

Leslie V. Norwalk, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244-1850

Re: File code CMS-1529-P

Dear Ms. Norwalk:

The American College of Physicians (ACP), representing over 120,000 doctors of internal medicine and medical students, welcomes the opportunity to comment on the proposed hospital direct and indirect graduate medical education policy changes in the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled *Medicare Program; Prospective Payment System for Long-Term Care Hospitals, RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes; Proposed rule.*

ACP appreciates the support expressed by both the Congress and CMS for residency training at ambulatory sites. Exposure to settings such as physician offices and community health centers are critical to the training of internal medicine residents, particularly those pursuing careers in office-based general internal medicine. They provide important educational experiences and are critical to residents' preparation for medical practice. However CMS's current approach to the counting of resident time spent in nonhospital settings has resulted in considerable confusion and concern among internal medicine training programs, leading many of them to suspend or eliminate nonhospital rotations. For some internal medicine programs that have chosen not to eliminate such rotations, the residencies and their sponsoring institutions have incurred a significant cost burden not only in paying nonhospital sites but also in engaging in efforts to comply with the regulations. These results directly counter Congressional intent to allow counting of resident time in these settings initially. The ACP supports CMS' attempt to clarify this situation and minimize administrative burden through this rule.

The College continues to be concerned about the following aspects of this proposed rule:

Definition of "All or Substantially All" Nonhospital Training Costs

ACP appreciates CMS's proposal to redefine the definition of "all or substantially all" to reduce the cost threshold. However, we believe that the 90% threshold is too high and could be further reduced to 75% and still meet the statutory definition. In a closely related regulation, known as the "Stark Rule", CMS has defined "substantially all" as 75% in the context of financial relationships between physicians and entities furnishing designated health services. In addressing the provision of services by physicians who are members of a group practice, CMS requires "substantially all of the patient care services of the physicians who are members of the group (that is, *at least 75 percent* of the total patient care services of the group practice members) must be furnished through the group . . ." 42 C.F.R. §411.352(d).

The Stark law, as enacted by Congress, utilizes the terms "substantially," and "substantially all." 42 U.S.C. § 1395nn (h) (4) (A), (B). In interpreting the statute, CMS claimed in its initial proposed rule that "the word 'substantial' generally means a considerable amount," and that 85 % would constitute "substantially all" of an amount. 57 Fed. Reg. 8588 (Mar. 11, 1992). Later, CMS lowered the threshold for "substantially all" to 75 %, a standard still in use today. 42 C.F.R. § 411.352(d); 60 Fed. Reg. 41914, 41931 (Aug. 14, 1995); 66 Fed. Reg. 856, 904, (Jan. 4, 2001).

Courts also have defined "substantially all" as being 75 percent or greater in the context of corporate and securities law. For example, in *Philadelphia National Bank v. B.S.F. Company*, the Delaware Chancery Court held that a corporation's sale of stock which represented at least 75 percent of its total assets was a sale of "substantially all" of its assets. 199 A.2d 557, 562 (1964).

Given CMS's previous interpretation, as well as the courts' interpretations, each designating the term "substantially all" to mean 75% or greater, the College believes that the 90% threshold proposed by CMS in this rule is too high. We recommend that CMS apply the same regulatory definition in this case and adjust the threshold in this rule to 75%. A threshold of 75% would meet the definition of "substantially all" and would lessen the barrier imposed by this rule to encourage training in non-hospital settings.

Three Hour per Week Presumption

ACP is very concerned that an inaccurate proxy for physician teaching time is being proposed within the rule. The proposed rule provides three hours per week as a presumptive standard number of hours that a teaching physician spends in nonpatient care GME activities at a particular nonhospital site. While we appreciate the effort to establish a proxy to address the administrative burden of collecting "real data", we believe the three hour presumption is a substantial overestimate of the typical teaching time commitment.

Internal medicine residencies employ the teaching services of nonhospital faculty for a number of educational rotations. However, the three hour per week presumption assumes that a resident spends a full week at a nonhospital site, which is often not the case. As a result, under the proposed rule, the three hour presumption creates an inappropriate weight for the time provided by training physicians at the nonhospital sites where a resident trains.

ACP strongly encourages CMS to revisit the three hour per week presumption to ensure that it reflects actual training experiences.

Effective Date

The proposed rule requests comments on the effective date of this rulemaking. ACP recommends that this rule be put in place the earliest effective date practical, as the current formula is overly burdensome. Clarity is needed as soon as possible for both programs and hospitals.

ACP appreciates the opportunity to provide these comments. If you have any questions concerning these comments, please contact Renee Zerehi, Manager of Health Policy, at 202-261-4555 or rzerehi@acponline.org.

Sincerely,

Lynne M. Kirk, MD, FACP
President

Submitter : Mr. Dennis Barry **Date:** 03/26/2007

Organization : Mr. Dennis Barry

Category : Hospital

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

We seek a clarification from CMS on the amount of cost for supervising physician services in a specific set of circumstances which occurs frequently for some programs affiliated with academic medical centers.

When a GME program operates in conjunction with a medical school, it is common for all or many of the teaching physicians to be medical school employees. Medical schools and affiliated faculty practice plans compensate their faculty physicians in a variety of manners.

Many of these compensation schemes have a two-tiered compensation structure. The first tier for teaching services is a fixed amount; a second tier of compensation for patient care services may vary in a relation to the volume of services furnished, amounts collected, and possibly other factors. (In some situations, there will be additional compensation to reflect excellence, research, administrative services, etc.) The point is that a portion of the physician s compensation for teaching services is negotiated at arms length between the physician and his or her employer, and that amount is known at the beginning of the academic year, but the total compensation for the physician is not. The amount paid for teaching physician services may be proportionately larger or smaller than the amount paid for patient care and other services, and is not known at the beginning of the year since the amount of time that will be spent on teaching and the volume and collections of patient care revenue are not known either at the beginning of a year.

Hospitals paying a medical school for teaching services should have the option of using the cost for teaching services as determined by the amount of compensation that is in good faith allocated to teaching activities by the medical school (or affiliated physician employer).

Sometimes faculty physicians work exclusively in nonhospital sites. Thus, the full amount of the compensation paid to such physicians is attributable to the teaching services furnished at that site. In other instances, a faculty physician supervises residents at both a nonhospital site and in the hospital. If the hospital reimburses the medical school for the full amount of its costs paid for teaching services, the hospital has necessarily incurred the full amount of those teaching physician costs for the nonhospital site, even if there is no agreed upon allocation of the physician compensation costs between the hospital and nonhospital site.

We request that CMS confirm that it believes that a hospital has borne the full costs of teaching services in nonhospital sites where services are furnished by medical school faculty physicians when the hospital reimburses the medical school the amount of compensation the medical school, in good faith, treats as compensation for teaching services, even when there is no allocation of those amounts between hospital and nonhospital sites.

In the event that CMS does not believe that this is an appropriate interpretation, we seek CMS s explanation for why this arrangement does not meet the statutory standards of the hospital bearing the full costs.

Submitter : Mr. Robert Reske **Date:** 03/26/2007

Organization : University of Michigan Hospitals and Health Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

SEE Attachment

CMS-1529-P-138-Attach-1.WPD

CMS-1529-P-138-Attach-2.WPD

#138

University of Michigan
Hospitals and
Health Centers

Accounting and Reimbursement Services
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March 26, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health And Human Services
Attention CMS 1529 P
P.O. Box 8015
Baltimore MD. 21244-8015

Re: (CMS-1529-P) Medicare Program; ...Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes, (Vol. 72, No .21, February 1, 2007 Page 4,818).

Dear Ms. Norwalk:

University of Michigan Health System (UMHS) appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule. Overall the UMHS supports the proposed rule and urges CMS to incorporate the following modification(s) of the definition of "All or Substantially All of the Costs for the Training Program in the Non-hospital Setting".

Payment For Direct Graduate Medical Education:

Implementation of the 90 Percent Threshold
Background:

The Accreditation Council for Graduate Medical Education (ACGME) is a private, non-profit council that evaluates and accredits medical residency programs in the United States. The mission of the ACGME is to improve health care by assessing and advancing the quality of resident physicians' education through accreditation. One of the criteria established by the ACGME for program accreditation is that the resident must be provided with clinical experience in efficient and effective ambulatory care settings. "...In addition to using hospital-based primary care or specialty clinics programs are encouraged to use community resources such as physician offices, neighborhood health centers, home–care and managed-care facilities to broaden the base of ambulatory care experiences for residents."

UMHS is an operating unit of the University of Michigan, a public university. UMHS includes a 913 bed hospital, a large ambulatory care network, and a medical school that is responsible for the education of more than 1,000 residents formally enrolled in over 70 ACGME accredited programs. As part of the required educational experience, the resident may rotate to one or more of 50 community-based sites. Based on the primary or specialty program the length of the resident's rotation may vary from a half day per week to over a full month.

Proposed Rule:

CMS proposes to define "all or substantially all of the costs for the training program in the non-hospital setting" to mean at least 90 percent of the total of the costs of the residents' salaries and fringe benefits and the portion of the cost of teaching physician salaries attributable to the direct Graduate Medical Education (GME). If the hospital does not meet the 90 percent threshold by only paying for the cost of the residents' salary and fringe benefits CMS proposes the hospital would have to meet the threshold by incurring some portion of the teaching physicians' salaries that is attributed to direct GME.

The hospital industry has voiced concerns with the CMS policy that requires a hospital to determine the portion of the teaching physician cost attributable to direct GME in the non-hospital site. The hospital industry believes that the CMS policy results in an untenable documentation burden since many teaching physicians are reluctant to disclose their salary information to hospitals. CMS therefore proposes to adopt an alternative methodology that hospitals may choose to use, instead of actual cost, to calculate the teaching physician costs associated with direct GME training at the non-hospital site.

CMS proposes to use 3 hours per week as a presumptive standard number of hours that a teaching physician spends in non patient care direct GME activities. The hospital would divide 3 hours by the number of hours the non-hospital site is open each week, to arrive at the portion of the teaching physician salary that is attributed to direct GME.

As referenced above, in order to provide a comprehensive medical education, the UMHS medical education program includes resident rotations to non-hospital sites. In some instances the rotation to the non-hospital site is for only a half day per week. UMHS believes that the CMS proposed policy will not provide relief from the untenable documentation burden, when the rotation to the non-hospital site is for a period that is less than one full day for the week.

UMHS Recommendation:

UMHS recommends the proposed policy be revised to include a calculation that will set a proxy for the average number of hours at one hour per week, when the rotation to the non-hospital site is for a period that is less than or equal to one full day for the week. By implementing the UMHS recommendation, CMS will eliminate the unrealistic outcome under the proposed policy, that 75% (3 hrs / 4 hrs) of the teaching physician and resident training at the non-hospital site is devoted to nonpatient care GME activities.

Physician Salary Information:

CMS proposes using the single national average or median salary amount for each medical specialty as a proxy for actual teaching physician salaries in non-hospital sites. CMS further proposes using annual survey data, such as that published by the American Medical Group Association (AMGA), which is nationally recognized, broad in scope, updated annually and available to the public at no cost. CMS has established Reasonable Compensation Equivalent (RCE) amounts for various medical specialties that are currently used in the determination of allowable physician teaching cost in the cost report.

UMHS recommends that rather than introduce another listing of physician compensation amounts CMS use existing RCE amounts as the proxy for determining average physician compensation in non-hospital training sites. This approach has the advantage of simplifying the administrative burden of maintaining multiple physician compensation listings and ensuring consistency within the Medicare cost report between teaching physician compensation in both hospital and non-hospital locations.

UMHS appreciates your attention to these comments and recommendation. Please contact me at 734-647-2579, should you or your staff have any follow-up questions.

Cordially,

Robert Reske
Hospital Financial Services
University of Michigan Hospitals and Health Centers

Submitter : Mr. Leo Greenawalt **Date:** 03/26/2007

Organization : Washington State Hospital Association

Category : Long-term Care

Issue Areas/Comments

Background

Background

See attachment

GENERAL

GENERAL

See attachment

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See attachment

LTC-DRG Classifications and Relative Weights

LTC-DRG Classifications and Relative Weights

See attachment

Other Proposed Policy Changes For The 2008 LTCh PPS Rate

Other Proposed Policy Changes For The 2008 LTCh PPS Rate

See attachment

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

Proposed Changes TO LTCH PPS Payment Rates For The 2007 LTCh PPS Rate Year

See attachment

CMS-1529-P-139-Attach-1.DOC

Washington
State
Hospital
Association

#139

March 26, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Re: Proposed Changes to LTCH PPS Payment Rates for the 2008 LTCH PPS Rate Year, Other Proposed Policy Changes for the 2008 LTCH PPS Rate Year

Dear Ms. Norwalk:

On behalf of our nearly 97 member hospitals, health systems and other health care organizations the Washington State Hospital Association (WSHA) is concerned by the changes to the long-term care hospital (LTCH) prospective payment system (PPS) proposed by the Centers for Medicare & Medicaid Services' (CMS). More specifically, we are troubled by CMS' 26 percent increase in the outlier threshold, proposed expansion of the 25 percent Rule on patient referral source, changes to the short-stay outlier policy and an offset for coding changes.

High Cost Outliers

CMS proposes a fixed loss amount of $18,774 for the 2008 rate year, compared to $14,887 for RY 2007. Such a drastic increase in the outlier threshold is difficult for a facility to adopt in such a short period of time. It appears this proposed threshold is calculated solely on the basis of reserving eight percent of total LTCH PPS payments to be used for outliers.

The arbitrary nature of this policy decision impairs facilities that are preserving access to quality care. Further, an increase in the outlier threshold without a subsequent increase in payment underscores the fact that payment levels are not keeping pace with the cost of providing quality care.

Inflationary Update and Behavioral Offset for Coding Changes

For RY 2008, CMS forecasts a LTCH PPS market basket of 3.2 percent based on the rehabilitation, psychiatric and long-term care market basket. Unlike most Medicare payment systems, federal statute does not require CMS to annually apply a full market basket update to the LTCH PPS. In fact, CMS proposes to partially offset the 3.2 percent market basket update with a coding adjustment of negative 2.49 percent, intended to account for coding increases in FY 2005.

For 2005, CMS calculated a *total* case mix index increase of 3.49 percent, which the agency believes is partially due to coding behavior, called "apparent case

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mix," and partially due to the increased cost of treating more resource intensive patients, called "real case mix." CMS based its projected growth in real case mix of 1.0 percent on experience and patterns in the general acute inpatient PPS. Therefore, for RY 2008, CMS is recommending a coding adjustment of negative 2.49 percent that reflects CMS' estimates of ***total*** case mix index increase minus ***real*** case mix index increase in FY 2005 (3.49 - 1.0 = 2.49). With the agency's proposed negative 2.49 percent coding adjustment, the actual RY 2008 update would be only 0.71 percent.

CMS should use the full market basket index projection for updating LTCH payments - the 2.49 percent downward adjustment is unwarranted. ***CMS' policies over the last two years have reduced LTCH payments by more than 7 percent. With hospital input costs increasing significantly due to inflation, a full market basket update is warranted.***

Expansion of the 25% Rule To Freestanding and Grandfathered LTCHs

In its fiscal year (FY) 2005 rule, CMS implemented payment limitations for LTCHs that are co-located with other hospitals in response to concerns about "inappropriate patient shifting" between acute care hospitals and LTCHs. Under the rule, when an LTCH is co-located with another hospital, no more that 25 percent of the LTCH's admissions from the co-located hospital will be paid at the full LTCH prospective payment rate. If the LTCH receives more than 25 percent of its admissions from the co-located hospital, the LTCH payments will be reduced for those patients exceeding the limit. CMS adopted the 25% Rule, in part, to address its concern that locating an LTCH within an acute care hospital might encourage the shifting of patients from host hospitals to co-located LTCHs for financial - rather than medically appropriate - reasons.

As part of its annual LTCH PPS payment update for 2008, CMS proposes to extend the 25% Rule to all LTCHs, including freestanding and satellite facilities, as well as LTCHs that were exempted from the original 25% Rule. To accommodate LTCHs located in rural areas or in metropolitan statistical areas (MSAs) served by one or more "MSA dominant hospitals" (i.e., hospitals that generate more than 25 percent of the Medicare discharges in the MSA), the agency increases the referral limitation to 50 percent. However, this move falls short of addressing the unique needs of most LTCHs and the general acute care hospitals that rely on them as part of their community's health care continuum.

As with the existing 25% Rule application, CMS' proposed expansion to all LTCHs lacks any meaningful relationship to the clinical appropriateness of LTCH admissions. LTCHs provide intense care to patients who require longer lengths of stay than a typical patient in an inpatient hospital, such as those on ventilators or burn victims. Any proposed policy regarding LTCHs should ensure access for patients for whom LTCH care is medically appropriate- a view supported by the Medicare Payment Advisory Commission. CMS is making payment decisions based on an arbitrary percentage. Last year, CMS released a report by the Research Triangle Institute (RTI) that identified feasible patient and facility criteria that would help distinguish LTCHs from other acute care facilities. However, CMS has not yet used the report to produce specific policy recommendations.

Rather than limiting access to LTCH services through payment cuts, we urge CMS not to move forward with the proposed rule, but to work with the RTI and LTCH providers to develop

appropriate facility and patient-centered criteria to determine the types of patients that should be treated in LTCHs.

Short-Stay Outliers

The LTCH short-stay outlier policy applies to cases with a length of stay up to 5/6 of the geometric mean length of stay for a particular diagnosis. In rate year (RY) 2007, CMS modified the LTCH short-stay outlier policy by adding the fourth payment alternative described below; as a result, Medicare payments to LTCHs were reduced by an estimated $156 million. Currently, short-stay outlier cases are paid the lesser of four payment alternatives:

- 100 percent of patient costs;
- 120 percent of the per diem of the LTCH DRG payment;
- the full LTCH DRG payment; or
- a blend of the general hospital inpatient PPS per diem and 120 percent of the LTCH PPS per diem. As a patient's length of stay increases, the LTCH DRG portion of the blend increases.

CMS' analysis of FY 2005 MedPAR data shows that 42 percent of LTCH short-stay outlier cases had lengths of stay that were less than or equal to the comparable length of stay (plus one standard deviation) for general acute care hospitals. Further data analysis shows that for ventilator and ventilator/tracheotomy patients, the number of post-intensive care days in the general acute care hospital drop significantly if the patient is discharged to an LTCH - 42 percent and 77 percent, respectively. From these analyses, CMS concludes that for cases with a length of stay equal to or less than the comparable general acute hospital stay, a full LTCH payment is inappropriate. The RTI included this proposal in its report to CMS last year.

LTCH patient severity and costs are very different from general acute care patients and validate the need for a separate LTCH payment. Concerns about early discharge from the general acute setting and "double" payment for LTCH cases are already addressed by use of the post-acute care transfer provision that reduces the PPS payment to general acute hospitals that discharge patients to an LTCH. The current short-stay outlier policy significantly reduces payments to LTCHs. Additional changes to further cut LTCH payment are unnecessary. ***We urge CMS to omit its proposed short-stay outlier policy from the final rule.***

If you have any questions, please contact me at LeoG@wsha.org or (206) 216-2500.

Sincerely,

Leo Greenawalt
President and Chief Executive Officer
Washington State Hospital Association

Submitter : **Dr. Kenneth Shine** **Date: 03/26/2007**

Organization : **University of Texas System**

Category : **State Government**

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

March 22, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8015
Baltimore, MD 21244-8015

Attn: CMS-1529-P

Dear Administrator Norwalk:

On behalf of the University of Texas System, I appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule entitled Proposed Direct and Indirect Graduate Medical Education Policy Changes (72 Fed. Reg. 4776, 4818).

Physician training in non-hospital ambulatory sites has become an increasingly important part of the resident training experience. The broad range of patients and conditions presented in an ambulatory setting provide an invaluable educational experience for resident physicians. Understanding the strides that have been made in adjusting Medicare policies to address the issue of payments for training in this setting, we are concerned that latest CMS proposal will result in a chilling effect on this important educational experience.

Congress has demonstrated support for non-hospital training opportunities, in particular those opportunities aimed at increasing the number of physicians in rural and underserved areas. As the number of physicians in these areas continues to decline, it is vital that federal policies encourage physicians to practice in these underserved areas. Particularly hard hit would be primary care residency programs which have historically relied on voluntary teaching faculty to educate their residents in non-hospital settings. The requirement that voluntary faculty may need to be paid a stipend will mean that educational opportunities for these community-based residents will now be determined by funding resources rather than teaching value.

Another concern we raise is that of the administrative burden posed by the proposed rule. Complying with the new standards to calculate didactic time as well as physician specialists stipends poses a colossal administrative task that takes away valuable time from our teaching and patient care mission. Hospital administrators may be unable or unwilling to pay a significant stipend to physicians in highly reimbursed specialties who ensure that the well-trained primary care doctors are able to provide cost effective, competent health care to patients. Teaching opportunities in specialties like ophthalmology, orthopedics, dermatology, and otolaryngology may be negatively impacted, as stipends according to the proposed rule would be inordinately high. More importantly, rural primary care residency programs will be negatively impacted at a time when America needs more physicians trained in primary care.

Finally, as a member of the Association of American Medical Colleges, the University of Texas System would like to echo the comments on this rule attributed by that organization. We urge CMS to modify the proposed rule to improve physician training in non-hospital settings, support rural physician training and reduce the administrative burdens on hospitals and residency programs.

Sincerely,

Kenneth Shine
Executive Vice Chancellor for Health Affairs
The University of Texas System

Submitter : Dr. Kevin Murray **Date:** 03/26/2007

Organization : University of WA Family Medicine Residency Network

Category : Academic

Issue Areas/Comments

Payment for Direct Graduate Medical Education

Payment for Direct Graduate Medical Education

Representing seventeen family medicine residency programs in the Northwest spanning five states (Washington, Wyoming, Alaska, Montana and Idaho), we are writing to adamantly oppose this proposal: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes.

Family medicine training in our region regularly occurs in the community. We rely heavily on preeeptors in the community to help train residents to be the kind of doctors that are needed in the largely rural areas of these five states in the Northwest.

Here are six critical points that we, as a consortium of 17 Family Medicine Residency programs, would like to make clear in our argument against this proposal:

1. We appreciate CMS's effort to define "All or Substantially All" to a threshold of 90 %. However that threshold is still too high and needs to be reduced to 75 %.

2. CMS should allow for physician volunteerism that most if not all of our community physicians provide.

3. CMS should allow programs / hospitals to exelude the costs of teaching physeians as part of the definition of "all or substantially all".

4. We recommend the 3 hour of non clinical didactic time be dropped to 1 hour per week as this most closely fits with the reality of this time in community preceptors offices. If the 3 hour non-clinical didactic per week rule is used then that should be prorated for the number of clinics that the residents have with the preceptor per week (for example many of our residents come back to the residency for their weekly clinics).

5. Hospitals / programs that are over their cap on residency slots as determined by BBA or BBRA have no duty to fulfill the requirements of this rule as the Medicare program is not paying for such training.

6. CMS has and will continue to adversely affect Family Medicine programs ability to train Family Physicians in community programs by having overly burdensome and onerous requirements for the use of community preceptors, none of whom see this as a problem.

In summary, the proposed policy would make training in the community difficult or impossible for most of our programs. This negative result is the opposite of what is needed to train family physicians for community practice.

Sincerely,
(See attached formatted letter with signature page. We are resubmitting this letter which was submitted earlier as it was missing the complete signature page)

CMS-1529-P-141-Attach-1.PDF

#141

UW Medicine
SCHOOL OF MEDICINE

Dept of Family Medicine

Residency Network

Box 354696

Seattle, WA 98195-4696

Tel: (206) 685-1856

Fax: (206) 685-8963

March 26, 2007

RE: CMS proposed 90% calculation

To Whom It May Concern:

Representing seventeen family medicine residency programs in the Northwest spanning five states (Washington, Wyoming, Alaska, Montana and Idaho), **we are writing to adamantly oppose this proposal**: *Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes.*

Family medicine training in our region regularly occurs in the community. We rely heavily on preceptors in the community to help train residents to be the kind of doctors that are needed in the largely rural areas of these five states in the Northwest.

Here are six critical points that we, as a consortium of 17 Family Medicine Residency programs, would like to make clear in our argument against this proposal:

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In summary, the proposed policy would make training in the community difficult or impossible for most of our programs. This negative result is the opposite of what is needed to train family physicians for community practice.

Sincerely,

Harold Johnston, M.D., Director
Alaska Family Practice Residency

Michael Tuggy, M.D., Director
Swedish First Hill Family Medicine Residency

Russell Maier, M.D., Director
Central Washington Family Medicine

Sam Cullison, M.D., Director
Swedish Family Medicine Residency Program
Providence Campus

David Ruiz, M.D., Director
Family Medicine of Southwest Washington
Family Practice Residency

Kevin Murray, M.D., Director
Tacoma Family Medicine

Gary Newkirk, M.D., Director
Family Medicine Spokane

Judith Pauwels, M.D., Director
University of Washington Family Medicine
Residency

Ted Epperly, M.D., Director
Family Practice Residency of Idaho

Tony Pedroza, M.D., Director
Valley Family Medicine

Sara Thompson, M.D., Director
Group Health Family Medicine Residency

Ron Dommermuth, M.D., Director
Puget Sound Family Medicine

Jonathan Cree, M.D., Director
Idaho State University Family Medicine Residency

Karen Wildman, M.D., Director
University of Wyoming Family Practice
Residency at Casper

Roxanne Fahrenwald, M.D., Director
Montana Family Medicine Residency

James Broomfield, M.D., Director
University of Wyoming Family Practice
Residency at Cheyenne

Kevin Haughton, M.D., Director
Providence/St. Peter Family Practice Residency