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FEB 23 2005

**RML**  
**SPECIALTY HOSPITAL**

February 14, 2005

Secretary Michael O. Leavitt  
Department of Health & Human Services  
Attn: CMS-1483-P  
P.O. Box 8011  
Baltimore, Maryland 21244-8011

RE: CMS-1483-P

Dear Secretary Leavitt:

RML Specialty Hospital (RML) is pleased to have the opportunity to present comments on the Prospective Payment System for Long Term Care Hospitals: Proposed Annual Payment Rate Updates, Policy Changes, and Clarifications published on February 3, 2004 in the Federal Register. I would like to commend the staff at CMS for their continuing efforts to address and refine the long term acute care hospital PPS system. As you are probably aware, this reimbursement system contains many complex issues.

By way of background, RML is a freestanding hospital licensed in the State of Illinois, that is considered for Medicare purposes, to be a pre-October 1997 LTCH facility. RML is a 501(c)3 not-for-profit limited partnership, whose members are Rush University Medical Center and Loyola University Medical Center. RML's primary focus is on ventilator weaning (respiratory), complex medical, and wound services. Because of our clinical program focus, RML has traditionally maintained a high case mix (one of the highest in the country) with a corresponding higher average length of stay than the typical LTCH. During the last 12-months, our overall case mix index fluctuated between 1.75 and 2.05 for Medicare patients. Patients treated at RML are referred from approximately 60 hospitals in Illinois. These patients primarily come from ICUs, surgical ICUs, critical care units, burn units, and step-down units.

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

1. As I have suggested in past communications, I believe the creation of a "site of service differential" for LTCHs as part of the LTC-DRG system is necessary. A site of service differential should recognize the inherent operating and capital expense differences between freestanding LTCHs and hospitals-within-hospitals. In prior updates and communications, CMS has suggested that they are concerned about compensating the host

hospital and hospital-within-hospital for "overhead and capital" associated with the space that is being leased. Hospitals-within-hospitals do not have the infrastructure reinvestment requirements that freestanding hospitals require. This is because "host" hospital facilities make the reinvestments in their physical plants. Medicare pays the host facility a capital component of a DRG in the short term DRG system and additionally Medicare pays the hospital-within-hospital a capital portion as part of its LTC-DRG payment. This is paying for the same physical location twice. Freestanding LTCHs have entire hospital physical plants to maintain; yet they receive the exact same capital reimbursement as hospitals-within-hospitals. There is no differentiation in the LTC-DRG system to correct this inequity. To further compound the situation even more, there are also significant operating expense differences between the two types of LTCHs. These "unit" versus "facility" differences must be recognized and the reimbursement system be modified to adjust for these significant "structural" differences. A site of service differential recognizing the difference between freestanding LTCHs and hospital-within-hospital LTCHs would correct these inadequacies

2. The rationale presented to maintain the transition period for the area wage rate implementation is not adequate. Operationally, LTCHs have already made the changes to adjust to the area wage component and enough time has passed for this transition to be fully implemented. Hospitals located within high-labor cost areas are bearing a greater burden of this transition methodology, while those facilities located in low-wage areas are receiving an added benefit. I suggest this be re-evaluated and an immediate 100% transition be implemented.
3. Several times throughout the proposed document, it is stated that the Secretary has broad authority in developing the LTC-DRG system, including the authority for appropriate adjustments. I have requested in the past for CMS to consider the opportunity for LTCHs to obtain an ESRD payment adjustment if they meet the same 10% threshold requirement that short term acute care hospitals must meet for additional payments. This would be a significant help in offsetting the additional treatment costs to those LTCHs that maintain high levels of Medicare dialysis patients. Dialysis patients require more staff and medical resources to treat than non-dialysis patients. For example, RML's average ventilator patient on hemodialysis costs over \$6,800 (nearly 15%) more per hospital stay than patients not receiving hemodialysis. These patients typically receive three hemodialysis treatments per week, at a direct cost of \$260/treatment, plus have longer than average lengths of stay and higher laboratory utilization. On treatment days, dialysis patients also require additional nursing care and typically receive frequent transfusions of blood and blood products, as well as injections of an expensive biotechnology drug (Aranesp) to maintain sufficient blood oxygen levels. Hemodialysis patients have labs drawn more often to check the blood for toxic levels of bio-waste products that

their kidneys cannot excrete without dialysis. Our referral sources have indicated there is an increasing need for RML to continue to treat these patients and our volume of hemodialysis patients has doubled since February 2004. I believe a dialysis add-on payment which is available to short term hospitals should be extended to the very small number of LTCHs who would meet this criteria.

4. I suggest that CMS allow freestanding long term acute hospitals the ability to establish "exempt" rehabilitation units. Because LTCHs no longer are reimbursed under the old cost-based system, the stipulation of not having an "exempt" unit within an "exempt" hospital is no longer valid. I do, however, make a clear distinction that this should only be permitted in freestanding LTCHs and not hospitals-within-hospitals.
5. I strongly support CMS's adjustments to the fixed loss outlier amount.
6. I applaud CMS's proactive efforts in studying the MedPac LTCH recommendations.

I appreciate the opportunity to comment on the proposed rule and CMS's willingness to request input from providers. The majority of the proposed rule is acceptable to RML. However, there are some concepts that could make the system better if implemented in the final rule. Specifically, the areas of concern to RML relate to: the lack of identification by CMS of the need to create a "site of service" differential as part of the LTC-DRG system, the inclusion of a payment adjustment for high volume dialysis patients, and eliminating the prohibition of freestanding LTCHs from establishing rehabilitation units.

RML is willing to work with CMS if there is a desire to explore some of these issues in more detail. If we can be of any assistance in the next evaluation process, please do not hesitate to call upon us. I can be reached at (630)286-4120.

Sincerely,



James R. Prister, FACHE  
President & CEO

JRP/dmg



**DIRECTORS**

MAR 23 2005

ARTHUR MAPLES, President  
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March 22, 2005

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**Via Overnight Mail**

Mark McClellan, M.D., Ph. D.  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health & Human Services  
Attention: CMS-1483-P  
P.O. Box 8011  
Baltimore, Maryland 21244-8011

**Re: Comments on Prospective Payment System for Long-Term Care Hospitals: Proposed Annual Payment Rate Updates and Policy Changes**

Dear Dr. McClellan:

The National Association of Long Term Hospitals ("NALTH") is pleased to present the following comments on the Centers for Medicare & Medicaid Services ("CMS") proposed rule on the Prospective Payment System for Long-Term Care Hospitals (LTCH-PPS): Proposed Annual Payment Rate Updates and Policy Changes that was the subject of a notice of proposed rulemaking ("NPRM") that appeared in the *Federal Register* on February 3, 2005, at 70 *Fed. Reg.* 5724.

**Proposed Changes to LTCH-PPS Rates and Policy for the 2006 LTCH-PPS Rate Year**

**1. Standard Federal Rate Update**

NALTH fully supports CMS' proposal to grant the full market basket increase of 3.1% for 2006, which will increase the Standard Federal Rate to \$37,975.53. This full increase will greatly aid NALTH members in meeting their costs in providing care to Medicare beneficiaries.

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## 2. High-Cost Outliers

NALTH fully supports CMS' methodology to use cost to charge ratios from the most recently filed hospital cost reports, which results in a significant reduction in the proposed fixed-loss amount of \$11,544 for the 2006 LTCH-PPS rate year. This reduction will assist LTCHs by limiting the financial loss that they must incur on these high cost cases.

## 3. Notification Requirement for Hospitals-within-Hospitals and LTCH Satellites

NALTH does not object to the CMS proposal to amend the notification obligation to place a continuing duty on LTCHs to notify its fiscal intermediary and CMS Regional Office of its co-located status and to identify by name, address and Medicare provider number those hospital(s) and units (IRFs and IPFs) and SNFs with which it is located. NALTH does request, however, that CMS be flexible in its enforcement with this provision. Although NALTH will notify its members of this new requirement, should it become effective, it is entirely possible that the notice requirement will in good faith be overlooked by a provider. We request that CMS adopt a flexible policy where a provider is found not to have conformed to the new notification provision, that it not be penalized. Instead CMS should inform the provider of the error and the provider should be given a reasonable time to correct the notice deficiency. Of course, this should not apply in the unlikely event that there is evidence a provider willfully and intentionally failed to file the applicable notice with its intermediary and the CMS Regional Office.

## 4. Extension of Surgical DRG Exception to 3-Day or Less Interrupted Stay Policy

CMS proposes to extend the exception to the 3-day or less interrupted stay policy for surgical DRGs for the 2006 LTCH rate year in order to have more complete data to better evaluate the exception. NALTH previously had suggested an extension of this nature and supports this proposal. NALTH further believes that surgical cases should be made a permanent exception to the 3-day or less interrupted stay policy.

## 5. Proposed Revision of LTCH-PPS Geographic Classifications

The proposed rule would substitute a new definition of labor market areas according to Core-Based Statistical Areas ("CBSAs") in lieu of the current Metropolitan Statistical Areas ("MSAs") and non-MSA, rural designations. NALTH has several comments on this proposed change.

First, there is an apparent discrepancy in the designation of Enid, Oklahoma under the proposed CBSA classifications. Integris Bass Pavilion LTCH, provider 37-2016, located in Enid, OK, is classified as being in a rural area (area 37) in Table 4 of the Addendum of the proposed rule (the two-digit code denotes a rural area). However, in Table 1 of the Addendum (the urban area wage index) of the same proposed rule, Enid,

OK is classified as an urban area (CBSA code 21420). There is a conflict within the rule as to whether Enid, OK, and therefore the LTCH located therein, in an urban or rural area. We request that this discrepancy be corrected in the final rule.

Second, the use of the CBSA-based designations is consistent with CMS' adoption of the CBSA-designations for use in IPPS rulemaking. CMS believes that the CBSA-based designations more accurately reflect the current labor markets, more specifically, the relative level of hospital wages and wage-related costs in the geographic area of the hospital compared to the national average. Using the same labor-market classification system for LTCHs as for IPPS facilities also is consistent with CMS' historical practice of modeling LTCH-PPS policy after IPPS policy. Unlike for IPPS hospitals, however, CMS continues to reject the opportunity for a LTCH to seek a geographic reclassification adjustment. LTCHs and IPPS hospitals in the same area compete for employees; in fact, many LTCHs are co-located with IPPS facilities. Both types of hospitals are acute care hospitals and compete with each other for most of their employees. NALTH suggests that the reclassification of some IPPS hospitals will cause distortions and disparities in the wages that an IPPS hospital may pay in relation to a nearby, much less a co-located, LTCH. NALTH notes, CMS states that no adjustment for geographic reclassification, as well as other adjustments such as DSH and IME, are proposed because the LTCH-PPS has only been implemented for a few years and there is not enough data available to enable a comprehensive reevaluation of these issues. *70 Fed. Reg. 5750*. NALTH contends that the absence of adequate data is not a valid and compelling reason to force a LTCH to try to compete with a nearby or co-located IPPS hospital for employees when the co-located IPPS hospital is awarded a higher wage level by the Medicare program. This is even more of a potential disparity when considering that many areas have a single dominant IPPS facility in the area. There simply is no valid policy reason to have differing wage adjustments for acute hospitals that compete for the same employees in the same labor market.

Accordingly, NALTH suggests either that a geographic reclassification be available for LTCHs, or CMS adopt a policy that if an IPPS hospital is awarded a geographic reclassification that the co-located LTCH similarly receive a corresponding adjustment to its payment level.

#### 6. MedPAC Recommendations/Monitoring

CMS has engaged Research Triangle Institute International ("RTI") to effectuate MedPAC's recommendations that the Secretary examine defining LTCHs by facility and patient criteria, including using Medicare claims data. In the preamble to the proposed rule CMS expresses its continued concern that its policies assure that LTCHs only treat patients for whom a LTCH level of care<sup>1</sup> is appropriate in order to assure that Medicare

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<sup>1</sup> Please clarify whether the use of the term "LTCH level of care" is intentional. Currently, LTCHs are recognized as acute care hospitals with a minimum 25-day average length of inpatient stay. LTCHs are subject to the same hospital level utilization review standards as apply to short-term acute hospitals. NALTH recognizes that within this context, LTCHs should offer programs of care which are qualitatively

is a prudent purchaser of services. CMS intends to develop criteria for appropriate admissions and to gather data to better understand the factors underlying extremely long-stay patients (those staying for periods of 6 months or more) as well as short-stay cases. CMS states that it intends, and has directed RTI, to gather information from LTCH industry stakeholders to assist with the information gathering and criteria-development on these matters.

Consistent with those intents expressed by CMS, NALTH has requested that CMS consult with the industry to examine these vital issues. Moreover, NALTH has offered to perform complimentary studies to determine appropriate admission criteria and develop a new definition of a LTCH. In fact, NALTH has developed admission criteria and anticipates engaging in further efforts to develop and validate continued stay and discharge criteria. However, to date NALTH has not been given a meaningful opportunity to collaborate with RTI or CMS on these issues. Although CMS has stated that the RTI studies will be conducted in two phases, CMS should open its work more to the public and seek further input from LTCH industry stakeholders in a fashion similar to that observed by CMS in developing the IRF criteria. For example, in developing the IRF PPS we understand that CMS convened a technical evaluation panel ("TEP") that invited representatives of the IRF industry to attend two meetings a year. These meetings provided significant information to the IRF representatives as well as provided the industry with a critical opportunity to comment on CMS ideas, information, and proposals. We understand that this was a highly interactive process that was of value to CMS. NALTH requests that CMS promptly institute a similar process of regular meetings between CMS and industry representatives to discuss these issues and attempt to jointly develop new definitions and admission criteria to ensure that CMS is a prudent purchaser of services.

We wish to underscore that the creation of new industry standards and definitions by CMS should be preceded by adequate and appropriate deliberative process which involves all stakeholders including patient representatives as well as hospital representatives. The absence of such a process may lead to unnecessary errors, misunderstandings and delays in the establishment of needed reforms. A change in Medicare policy of the magnitude contemplated by the MedPAC report and that contained within the RTI study, as described in the preamble to this rulemaking, should be preceded by more than the minimum number of days required for notice in the rulemaking process under the Administrative Procedure Act. Accordingly, NALTH strongly recommends that CMS engage in an open and frank consultation with all stakeholders in the development of new long-term care hospital Medicare criteria and standards.

As for the data collection itself we, note that the patients who have stays in excess of 6 months will have exhausted their Medicare day benefits and no longer are Medicare beneficiaries. The development of new LTCH admission criteria and definitions of what

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distinct from a mere continuation of ongoing services in an acute care hospital. NALTH is of the view that services appropriately provided in a LTCH are "acute" while taking into account peaks and valleys in medical condition of longer stay hospital patients.

Mark McClellan, M.D., Ph. D.

March 22, 2005

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constitutes a LTCH must consider that the level of care and medical resources available within SNFs are other non-hospital facilities varies greatly across the country. The level of care provided at, for example, a skilled nursing facility may depend on a variety of factors, ranging from state Medicaid hospital admission and funding policies to the number of alternative providers available in the area. It, therefore, appears both reasonable and appropriate, for the Secretary to embrace the patient centered processes which are prescribed for QIOs which are to reflect local patterns of care in making coverage decisions. NALTH urges CMS, as it establishes patient and facility criteria, to carefully consider and reflect patient safety issues. Patient and facility criteria should reflect whether, as a practical matter, resources are available on a patient specific basis. These issues require medical review to assess the medical appropriateness of the admission decision; simply reviewing the Medpar files or other administrative data collected by CMS, is not sufficient to fully understand the admission decision.

NALTH suggests that the QIOs have been, and will continue to be, the best vehicle to resolve questions regarding the appropriateness of admissions, rather than CMS imposing an inflexible regulatory requirement. NALTH is committed to working together with CMS to develop solutions to these issues, and requests that it be consulted by CMS as it develops new standards for patient admission and continued stay in a long-term care hospital.

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

Sincerely,



Edward D. Kalman  
General Counsel



**HEALTHSOUTH** 2005 MAR 29 AM 9:41

March 25, 2005

Mark B. McClellan, M.D., Ph.D.  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1483-P  
P.O. Box 8011  
Baltimore, Maryland 21244-8011

OPTIONAL FORM 98 (7-80)

**FAX TRANSMITTAL**

# of pages

To	Donald Hart	From	T. Mims
Dep. Agency	OSORA/ReasB	Phone #	690-0748
Fax #	417810-3084	Fax #	21205-9531
NSN 7540-01-317-7368		5099-101 GENERAL SERVICES ADMINISTRATION	

Dear Mr. Administrator:

HealthSouth Corporation is one of the nation's largest providers of post acute health care services and operates facilities nationwide. We appreciate the opportunity to comment on the February 3, 2005 proposed rule by the Centers for Medicare and Medicaid Services ("CMS") for the Long-Term Care Hospital (LTCH) Prospective Payment System.

HealthSouth supports the proposed rule and we concur with the rationale utilized by CMS to update LTCH payment rates and policies. We would, however, like to offer several specific recommendations for modification of the proposed rule.

1. **Proposed Changes to LTCH PPS Rates and Policy for the 2006 LTCH PPS Rate Year**

We have some concerns relating to the development of the Proposed Fixed-Loss amount for Outlier Payments. Since the implementation of the LTCH PPS, CMS has set a Fixed-Loss threshold to determine which cases will qualify for Outlier status. This Outlier threshold has significantly decreased with each rule update as demonstrated below:

FY 2003	\$24,450
FY 2004	\$19,590
FY 2005	\$17,864
FY 2006 (Proposed)	\$11,544

As noted in the preamble to the proposed rule, "We (CMS) set the outlier threshold before the beginning of the applicable rate year so that total outlier payments are projected to equal 8 percent of total payments under the LTCH PPS." The preamble goes on to state that "based on claims discharged during the 2004 LTCH PPS rate year (July 1, 2003 through June 30, 2004), we estimate that outlier payments equal about 6 percent of total LTCH PPS payments." It appears from these statements that the process utilized by CMS to project Outlier payments has resulted in roughly 2 percent of the

Mark B. McClellan, M.D., Ph.D.

March 25, 2005

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Outlier budgeted funding to not be paid to providers. We assume that a similar forecast error occurred or may have occurred in other LTCH rate years.

On August 4, 2003, CMS issued a final rule for the Skilled Nursing Facility (SNF) Prospective Payment System. This rule included a one-time forecast correction of 3.26 percent to reflect the difference between the market basket forecast and the actual market basket increase from the start of the PPS in July 1998. Additionally, CMS established a benchmark that future market basket forecast differences in excess of .25% would be adjusted in future rate period updates. This measurement was applied to the FY 2005 SNF PPS rule update that fell below the .25% at .20%. While we recognize that the SNF market basket rate update and the LTCH outlier threshold issues are different, the underlying premise is the same – they are designed to alleviate the effect of potential errors in the forecast methodology to ensure appropriate payment amounts.

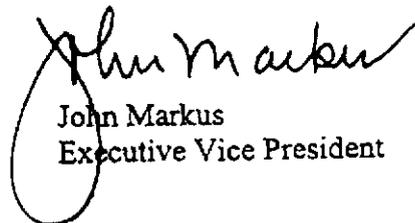
We recommend that CMS implement a similar one-time adjustment to the LTCH PPS federal payment rate to account for these unexpended Outlier funds since the inception of the LTCH PPS. Additionally, we request that consideration be given to the implementation of a threshold to ensure that all Outlier payments are actually paid to providers.

## 2. Section IX. MedPAC Recommendations/Monitoring

We understand that a contract has been awarded to RTI International for a thorough examination of the feasibility of implementing the MedPAC recommendations relating to LTCHs contained in its June 2004 Report to the Congress. We agree with the MedPAC recommendation to define long term care hospitals by facility and patient criteria to ensure that patients admitted to these facilities are medically complex and have a good chance for improvement. The development of robust clinical quality measures and best practices will best be accomplished through the involvement of the provider community in this very important research. We are currently working to enhance our own admission criteria and would be interested in reviewing the results of RTI study.

We appreciate the opportunity to comment on the proposed rule. If you have any questions, please feel free to call me at (205) 970-8158.

Sincerely yours,



John Markus  
Executive Vice President

cc: M. Tarr  
R. Wisner  
J. Hunter

## Acute Long Term Hospital Association

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1055 North Fairfax Street, Suite 201 • Alexandria, VA 22314 • Phone (703) 299-5571 • Fax (703) 299-5574

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
**File Code: CMS-1483-P**  
Room 443-G Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

Re: Reference: 42 CFR Part 412  
Medicare Program; Prospective Payment System for Long-Term Care Hospitals;  
Proposed Annual Payment Rate Updates and Policy Changes; Proposed Rule

March 29, 2005

Dear Administrator:

The Acute Long Term Hospital Association (ALTHA) wishes to provide comments to the rule proposed by the Centers for Medicare and Medicaid Services (CMS) regarding annual payment rate updates and policy changes for long-term acute care hospitals (LTACHs). ALTHA represents the interests of over 245 LTACHs in 29 states, specializing in intensive care for long-stay patients. These hospitals focus on patients with medically complex conditions and/or multiple conditions. Many patients arrive directly from intensive care units of general hospitals, often still on life support. Our aggressive clinical and therapeutic intervention generally involves daily physician monitoring, 24-hour RN care, significant ancillary services and complicated medication regimens.

ALTHA's mission is to defend patient access to specialized, appropriate and high quality long-term acute care. Such access is critical to achieving high levels of medical recovery and returning patients home to their families. ALTHA works to protect the rights of medically complex patients and the hospitals that treat them by educating federal and state regulators, Members of Congress and healthcare industry colleagues. ALTHA also works to increase quality of care by sharing and improving best practices among its members.

ALTHA concurs with the vast majority of the rule's proposed changes. We recognize the complexity of the LTACH prospective payment system – consistent with the complex care needs of our patient base – and the difficult tasks put to CMS' staff to ensure a fair and proper payment structure and reimbursement system. We recognize the important role that the Administrator plays in being a "good steward" of the federal budget and ensuring that, in all care settings, the appropriate patient is receiving the most appropriate care for the appropriate payment. We believe ALTHA-member hospitals fit that mold well and we hope to work with CMS to meet these and other goals.

## 1) Review of MedPAC's Recommendations

### a. Overview

In order to ensure proper payment for proper care, and in response to the June 2004 report of the Medicare Payment Advisory Commission (MedPAC) recommending that the Secretary consider defining LTACH by facility and patient criteria, CMS has awarded a contract to Research Triangle Institute International (RTI). The rule states that RTI will conduct "a thorough examination of the Commission's recommendations based on the performance of a wide variety of analytic tools using CMS data files and also utilizing information collected from physicians, providers and LTCH trade associations." The study will also examine the present role of quality improvement organizations (QIOs) by focusing on their responsibility regarding the LTCH prospective payment system (PPS) and the potential for an expanded QIO role as recommended by the Commission.

MedPAC's overall objective is to establish criteria that clearly distinguish the LTACH level of care from other treatment settings, by establishing both facility and patient criteria for LTACHs that differentiate their type and level of care and types of patients appropriate for such care. Consistent with Medicare's goals for all treatment settings, MedPAC is recommending that, in the future, payments be tied to improvements in quality of care and maintenance of high quality care. We believe the goal of clearly distinguishing LTACH facilities, treatment, and patients is good health care policy. MedPAC's recommendation specifies that LTACH designation should be limited to the medically complex patient population. Many of the criteria recommended by MedPAC are already met by the vast majority of LTACHs as a result of their hospital level of care and the medical complexity of their patient populations.

ALTHA believes that specific criteria should be carefully considered and based on patient clinical treatment requirements and practices. We believe all LTACHs should meet specific criteria to ensure they can provide the resource-intensive and specialized services LTACH patients need. As a trade association representing roughly two-thirds of the entire LTACH industry, ALTHA is well-positioned and eager to assist in this project in any way possible.

In fact, several leading ALTHA-member companies are working collaboratively on an evaluative study of the LTACH provider community with a focus on patient and facility level characteristics. This work has found that a set of LTACH certification criteria should be centered on three main categories:

- **Patient Characteristics.** LTACH criteria should encourage LTACHs to serve a medically complex patient population. The majority of LTACH patients should have multiple co-morbid conditions that complicate their primary diagnosis. There are two relevant proxies for measuring and monitoring this medical complexity:
  - *Retain the current requirement for a 25-day average length of stay for Medicare beneficiaries.* The 25-day length of stay requirement is one reasonable proxy for medically complex care provided to patients who often need long hospital stays as part of their treatment; and
  - *Create a new severity of illness threshold.* At least 50 percent of every hospital's Medicare discharges during its cost report year would be classified into either severity of illness level (SOI) three or four. The severity of illness level is based on the 3M APR-

DRG classification system and would require that every facility use this grouper software to ensure that, over a year, at least half of their Medicare discharges are classified in SOI three or four.

- **Structure.** The second LTACH certification criterion should be aimed at ensuring that the facility is organized and operated to support the complex care required for its patients. Currently, major LTACH providers are licensed as acute care hospitals, receive JCAHO accreditation, and meet CMS' hospital conditions of participation. While these quality monitoring mechanisms are important, more requirements are necessary to ensure that LTACHs have the capability to meet the unique needs of the medically complex LTACH patient population. Long-term acute care hospitals should have criteria that require them to have structural elements in place to deliver the appropriate care (e.g., daily physician contacts, availability of respiratory therapy, and interdisciplinary team assessments).
- **Admissions and Continued Stay.** The third criterion for LTACH certification should ensure that admissions and continued stay standards are in place so that LTACHs serve the most medically complex patients. The implementing regulations for the LTACH prospective payment system (PPS) direct the QIOs to perform greater oversight of LTACH utilization assessment and medical necessity review process (42 CFR412.508(a)). The certification criteria should specify that QIO review be based on a nationally uniform set of admissions and continuing stay criteria.

These certification criteria are very similar to those recommended by MedPAC. The study that will begin this spring will attempt to examine these criteria and MedPAC's more closely. We hope the results from this study can contribute meaningful information and data to future policy discussions regarding LTACH certification criteria.

#### b. Recommendations

ALTHA strongly supports the development of LTACH certification criteria using facility and patient characteristics. We believe research findings from the CMS/RTI research study of the LTACH provider community will be a significant aid in developing new LTACH certification criteria. ALTHA requests that CMS consider the findings from the above-mentioned evaluation of LTACH provider community characteristics and practices in conjunction with the RTI study.

In the absence of a formal technical expert panel, CMS should require RTI to work openly and collaboratively with the LTACH provider community in developing new certification criteria. Unlike inpatient hospitals or nursing facilities, there is little publicly available data providing information about LTACH patient outcomes and quality improvement activities. The LTACH provider community does have this data and RTI should work collaboratively with the community to obtain the best data possible. This is imperative for the successful development of certification criteria that reflect LTACH care. MedPAC has recognized this lack of publicly available LTACH data as well and acknowledges the need for close coordination with the LTACH provider community. A collaborative effort will provide the most accurate data and information about this provider group.

## 2) Quality Measures

### a. Overview

CMS states in the proposed rule that it currently does not require LTACHs to submit any clinical or other

quality data. CMS is considering what additional data would be required for developing clinical quality measures for LTACHs and is currently evaluating whether CMS' Quality Measurement and Health Assessment Group should develop a quality measurement program for LTACHs. In the proposed rule, CMS stated quality measurement domains for LTACHs should reach a broad population, be based on medical evidence, be scientifically valid, and be actionable. In addition, CMS stated it would consider measures that cut across other care delivery sites and focus on areas such as medication management or patient safety.

*b. Recommendations*

ALTHA strongly supports CMS' proposal to develop a quality measurement program for LTACHs and encourages CMS to develop these measures in partnership with the LTACH provider community. We suggest an expert panel be formed to oversee and guide the development of quality measures for LTACHs. This panel should include physicians and other LTACH professionals, such as respiratory therapists. In addition, we recommend that CMS establish an LTACH-specific quality initiative to employ these new quality measures. We encourage CMS to consider an initiative similar to the Hospital Quality Initiative where hospitals are given a financial incentive (0.4% higher annual payment update) for reporting quality measures. The development of an LTACH quality initiative should be done in cooperation with the LTACH provider community, the Federation of American Hospitals, and ALTHA to ensure that measures are appropriately risk-adjusted and can be used to improve quality over time.

We thank you for the opportunity to present our views. Please do not hesitate to contact us if you have any questions or comments.

Sincerely,

Brad Traverse  
Executive Director

**Massachusetts Hospital  
Association**

March 28, 2005

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1483-P  
P.O. Box 8011  
Baltimore, MD 21244-1850

**RE: Proposed Changes to the LTCFH PPS Rates and Policy for the 2006 LTCH PPS  
Rate Year**

The Massachusetts Hospital Association (MHA), on behalf of our member hospitals and health systems, submits this letter to comment on the 2006 proposed Long-Term Care Hospital Prospective Payment System. Massachusetts is home to many of the nation's long-term care hospitals (LTCH) that provide some of the most clinically complex post-acute hospital care. Given this large number of providers, we believe a few aspects of the proposed rule will not fairly reimburse these hospitals for this care and have significant implications for the way they will be able to treat Medicare beneficiaries. In addition, these policies also implicate the reimbursement process and create significant delays on the payment process that also needs to be addressed in the final rule. To that end, we submit these comments for your review.

**Payment Updates and Outlier Fixed-Loss Amount:**

At the outset, MHA would like to state our support for the reduction in the outlier fixed-loss amount and the 3.1 percent market basket update on the proposed federal payment rate. Both changes reflect the changes in the LTCH market and will continue to assist the LTCH in providing timely and appropriate level of care for Medicare beneficiaries.

**Proposed Revision of the LTCH PPS Labor Market Areas:**

MHA believes that the proposal to immediately implement the CBSA-based designations after the IPPS policy without the same transition, adjustments and reclassification opportunities for Long Term Care Hospitals could be disastrous for some hospitals. LTC hospitals in Essex County, Middlesex County, and Worcester County would be at a severe competitive disadvantage in recruiting and retaining workers since they compete not only with hospitals in the new Boston-Quincy CBSA but also with acute hospitals in their counties that are paid under the transition rule, with the automatic out-migration adjustment, and been allowed to reclassify to the Boston-Quincy CBSA. Workforce shortages in Massachusetts are serious for all providers and all providers will be affected by the revised wage areas.

If the stated goal of immediately adopting the CBSA designations is to provide consistency and stability in the Medicare program payment process, then the rule must also recognize that the LTCH operates in the same labor market as the acute care hospitals and be afforded the opportunity to account for the variation in hospital labor costs. For example, LTCH in the Essex county CBSA would qualify for reclassification to the Boston-Quincy CBSA, under the criteria for geographical reclassification of 42 CFR 412.230.

**Extension of the Interrupted Stay Policy:**

MHA supports the decision to extend the surgical exceptions to the interrupted stay policy to reflect those surgical services that are deemed a major procedure. However, as CMS plans to further review the possibility of further extending this policy, we would request that the agency first convene a technical advisory group of hospitals and CMS staff to discuss any proposed changes. When CMS first developed in the policy in the 2005 LTCH rule, there was little to no communication with those hospitals that were substantially impacted by these policy changes. Therefore, we request that the agency discuss any proposed changes to the hospitals community through a technical advisory group prior to developing these changes in the 2007 or future proposed rules.

**Financial Impacts of the Interrupted Stay Policy and Current Reimbursement Procedures:**

MHA would also like to request three specific system edits to the FISS and Common Working File (CWF) to coincide with the July 1, 2005 LTCH 2006 rule start date. Each of the requested edits is related to problems that result from the LTCH interrupted stay policy that prevents an LTCH from receiving timely and appropriate reimbursement due to current system limitations. Making these changes effective on the start date of the 2006 final rule is important and crucial to LTCH providers.

First, under the interrupted stay provisions the LTCH is responsible for making payments to an acute or other site of service that provides ancillary service such as imaging type services under arrangement with the LTCH. However, due to the lack of communication and education by CMS to the other provider types of this change in policy, there continues to be an overlapping of claims. The most common example is an acute who bills for a CAT scan instead of billing the LTCH, the acute level hospital continues to bill the intermediary and to be paid; the LTCH claim is then rejected because there is an overlap in the service dates (the denial based on Reason Code 38067). There is no indication in the FISS system for providers to see who performed the ancillary service, as a result the LTCH financial staff has to initiate a call to their FI to have the FI adjust the acute facility claim and to suspend the LTCH claim until resolved. This creates substantial time and costs on both the hospital and FI staff. **MHA proposes** that the CWF be edited to allow the uninterrupted inpatient LTCH claim to post to the CWF (based on the claim showing an uninterrupted inpatient stay during the period of the overlapping claim with no discharge to home); the FISS automatically cancel the outpatient bill; and there be an electronic notification to the outpatient provider of both the reason for the cancellation (the reason code 38067) and the name and provider number of the other provider responsible for reimbursement on the service.

Second, Medicare payment systems also have an edit in place that if an LTCH submits a claim to Medicare and an acute care hospital submits a clean claim with a discharge code other than 63 (which is return to LTCH code), the claim is automatically rejected (reason code 38114). Again, there is no indication in the FISS system for providers to see who billed this service, as a result the LTCH financial staff has to initiate a call to their FI to have the FI adjust the acute facility and to suspend the LTCH claim until resolved. The LTCH financial staff must again manually call their FI to manually suspend the claims for internal review, amend the discharge code, and process the LTCH claim. **MHA proposes** that the CWF should also be edited to essentially allow the inpatient LTCH claim to post to CWF and to issue an automatic response for cancellation of the inpatient claims in history with the patient status or discharge code.

Third, Medicare pays based on when the claim are received to be processed by their system and not in the order that the service was performed. This leads to payment problems that would not occur if the claims were paid in the correct order. When an LTCH has a bill rejected or held up by the system, it then allows for a later admission to an acute facility to be processed and paid. This then will deny or suspend the LTCH claim because the days available for use are different than what the CWF reports. To have the LTCH claim processed and paid correctly, CMS must recoup the money from the Acute, then both the LTCH and the Acute can be resubmit the bill for payment. **MHA proposes** that there should be an edit in the CWF that would allow payment on an LTCH claim if either the patient is a new admission (admitted from a patient's home or a nursing home, and not from another hospital) or by accounting for all days during the patient's spell of illness starting with the initial date of admission until the patient discharge status is home (01), SNF (03) or expired (20)

If I can provide you with any additional information regarding our comments, please do not hesitate to contact me at (781) 272-8000, ext. 173.

Sincerely,



James T. Kirkpatrick  
Vice President, Health Care Finance and Managed Care



2004 03 29 0 11 11

Charles N. Kahn III  
President

March 29, 2005

Dr. Mark McClellan, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
**File Code: CMS-1483-P**  
Room 443-G Hubert H. Humphrey Building  
200 Independence Avenue, S.W.  
Washington, DC 20201

**Re: Reference: 42 CFR Part 412  
Medicare Program; Prospective Payment System for Long-Term Care  
Hospitals: Proposed Annual Payment Rate Updates and Policy Changes;  
Proposed Rule**

Dear Administrator McClellan:

The Federation of American Hospitals ("FAH") is the national representative of privately owned or managed community hospitals and health systems throughout the United States. In addition to teaching and non-teaching hospitals in urban and rural America that provide a wide range of acute and post-acute services, our members comprise more than one-half of the long-term care hospitals in America, both freestanding and hospitals-within-hospitals. We appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' ("CMS") proposed rule regarding the prospective payment system for long term care hospitals (LTCHs).

• **MedPAC Recommendations**

FAH supports the thrust of the Medicare Payment Advisory Commission's (MedPAC) recommendations that:

1. LTCHs should be defined by facility and patient criteria to ensure patients admitted to LTCHs are medically complex and have potential for improvement.
2. Quality Improvement Organizations (QIOs) should be required to review LTCH admissions for medical necessity and monitor LTCH compliance with defining criteria.

FAH further supports CMS' decision to engage CMS/RTI International in a research study of the LTCH provider community to help develop new LTCH certification criteria along the lines recommended by the MedPAC.

To enhance the accuracy and credibility of this research and to strengthen its findings, FAH believes that CMS should require its researcher, RTI International, to work in a collaborative and transparent manner with the LTCH provider community, which currently is compiling critical data about patient outcomes, quality improvement activities and other key potential certification criteria, for which there is little public information.

- **Quality Measures**

FAH supports CMS' proposal to develop a quality measurement program for LTCHs and urges that it do so in partnership with the LTCH provider community. FAH is very pleased with the partnership – the Hospital Quality Alliance -- it has established with CMS in developing quality reporting measures for short-stay acute care hospitals, including the current financial incentive, and believes that positive experience should guide CMS as it moves forward with reporting and measuring quality in long term acute care hospitals. Along those lines, CMS should establish an expert panel comprising, among other LTCH professionals, physicians and respiratory therapists. FAH would be happy to work with CMS and others to help develop appropriate LTCH quality measures.

- **Monitoring LTCH Length of Stay**

FAH supports CMS's efforts to collect data regarding patients who may stay in LTCHs for a significant period, to involve QIOs in evaluating such stays for medical necessity of patients, and to monitor short-stay outlier policy implications. As it does so, and as it may consider various policy responses, CMS must be mindful that it can be extremely difficult for many LTCH patients to find appropriate placement outside the facility. Indeed, it is not uncommon for family members to refuse to discharge the patient. In addition, the agency must be careful not to interfere with the physician's ability to exercise independent medical judgment as to the appropriate level of care that is in the patient's best interests.

- **Fixed-Loss Amount**

FAH agrees with CMS' use of the Medicare Provider Specific File to determine cost-to-charge ratios for the purpose of establishing the fixed-loss amount, rather than using older HCRIS data. This file clearly offers the best available data. The resulting reduction in the fixed loss amount should help ensure that the eight percent of LTCH payments set aside for outlier payments – the appropriate level – will be expended. As CMS notes, total outlier payments in the 2004 and 2005 rate years were less than the eight percent of total Medicare LTCH payments set aside for this purpose. The lower fixed loss amount will help defray the losses sustained by an LTCH in treating these high cost cases and will increase beneficiary access to care by encouraging facilities to accept these difficult-to-treat patients.

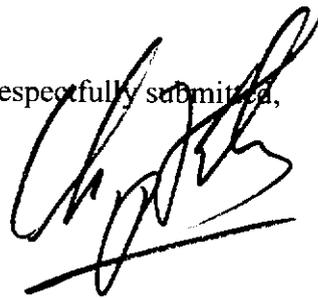
Dr. Mark McClellan, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
March 29, 2005  
Page 3 of 3

- **Estimated Total LTCH Medicare Payments**

While CMS's estimated total LTCH payments for 2006-2009 have dropped compared to the corresponding estimated total LTCH payments published in the 2005 final rule, FAH notes that neither set of estimates reflects recent major policy changes regarding LTCH hospitals-within-hospitals, promulgated as part of the August 2004 IPPS final rule for FY05. These provisions will be phased in over four years beginning in October 2005, and FAH believes that they will further slow the growth in LTCH Medicare spending. We recommend that CMS estimate the fiscal effect of these changes in its estimates of total Medicare LTACH payments to ensure that policy-makers understand their fiscal impact and take that into account as they may consider various LTCH payment and policy changes.

Thank you for your attention to our comments. We would be happy to meet with you and your staff to discuss these issues at your convenience. If you have any questions, please do not hesitate to contact me or Steve Speil, Senior Vice President and Chief Financial Officer, of my staff at (202) 624-1529.

Respectfully submitted,

A handwritten signature in black ink, appearing to be "Cheryl", written over a horizontal line.

March 29, 2005  
Mark McClellan, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Avenue, SW  
Washington DC 20201

**Re: File code CMS-1483-P**

Dear Dr. McClellan:

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: Proposed Annual Payment Rate Updates, Policy Changes, and clarification; Proposed Rule, 70 Fed. Reg. 5724*

(February 3, 2005). We appreciate your staff's work on this prospective payment system, particularly given the competing demands on the agency. We have six comments, many based on analyses we conducted and presented in the Commission's June 2003 and June 2004 reports.

First, the Commission notes the rapid growth of long-term care hospitals (LTCHs) and the consequent rapid growth in Medicare spending. LTCHs more than tripled (105 v. 350) from

1993 through 2004. Medicare spending for care furnished in these facilities has increased almost

8-fold from \$398 million in 1993 to an estimated \$3 billion for rate year 2006. In the last year

alone, Medicare certified over 30 new LTCHs. The growth in facilities in the last few years,

largely driven by the increase in for-profit facilities, is one factor that suggests Medicare payments for these facilities may be more than adequate.

Second, the uneven geographic distribution of these entities suggests that similar Medicare

patients are served in alternative settings, such as acute care hospitals or skilled nursing facilities

instead of LTCHs. This raises the possibility that at least some of these patients can be cared for

by other, perhaps less expensive providers.

Third, we found that patients treated in long-term care hospitals cost Medicare more on average,

but the difference was not statistically significant when the comparison focused on patients most

appropriate for LTCH care. As a result, we recommended that long-term care hospitals be defined by facility and patient criteria that ensure that patients admitted are medically complex

and have a good chance of improvement. We also recommended that the Quality Improvement

Organizations review admissions for medical necessity and monitor these facilities for compliance with the defining criteria. Details of these recommendations are available at [www.medpac.gov](http://www.medpac.gov).

Fourth, we agree with your requirement that LTCHs-within-hospitals report to you when they

are colocated with other providers and the provider numbers of the colocated facilities.

This will

allow policymakers and researchers to systematically identify LTCHs-within-hospitals and

monitor them.

Fifth, we are pleased that you are in accordance with our recommendations and look forward to

the results of your study of the feasibility of implementing them. We also look forward to the

results from the other research on LTCHs you are conducting, including:

- Comparison of LTCH patients and outlier patients in acute care hospitals;
- Examination of LTCH patients with diagnoses typically seen in inpatient rehabilitation facilities;
- Medical record reviews to monitor changes in service use over time;
- Evaluation of long-term LTCH patients to determine whether they should be treated in skilled nursing facilities; and
- Examination of LTCHs' patients to determine whether they are being retained in

LTCHs

beyond their need for LTCH-level care.

Finally, we encourage CMS to examine carefully the evidence that LTCHs may be paid more

than adequately and use the agency's authority to correct any discrepancy in the PPS rates. We

believe that long-term care hospitals raise significant questions for Medicare's post-acute care

services and that both MedPAC and CMS must continue our work to answer these questions.

Sincerely,

Glenn M. Hackbarth

Chairman

GH/SK/amd

APR 1 2005 Read by  
Tom

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# ACUTE LONG TERM HOSPITAL ASSOCIATION

1055 North Fairfax Street, Suite 201 • Alexandria, VA 22314 • Phone (703) 299-5571 • Fax (703) 299-5574

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
**File Code: CMS-1483-P**  
Room 443-G Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

Re: Reference: 42 CFR Part 412  
Medicare Program; Prospective Payment System for Long-Term Care Hospitals;  
Proposed Annual Payment Rate Updates and Policy Changes; Proposed Rule

March 29, 2005

Dear Administrator:

The Acute Long Term Hospital Association (ALTHA) wishes to provide comments to the rule proposed by the Centers for Medicare and Medicaid Services (CMS) regarding annual payment rate updates and policy changes for long-term acute care hospitals (LTACHs). ALTHA represents the interests of over 245 LTACHs in 29 states, specializing in intensive care for long-stay patients. These hospitals focus on patients with medically complex conditions and/or multiple conditions. Many patients arrive directly from intensive care units of general hospitals, often still on life support. Our aggressive clinical and therapeutic intervention generally involves daily physician monitoring, 24-hour RN care, significant ancillary services and complicated medication regimens.

ALTHA's mission is to defend patient access to specialized, appropriate and high quality long-term acute care. Such access is critical to achieving high levels of medical recovery and returning patients home to their families. ALTHA works to protect the rights of medically complex patients and the hospitals that treat them by educating federal and state regulators, Members of Congress and healthcare industry colleagues. ALTHA also works to increase quality of care by sharing and improving best practices among its members.

ALTHA concurs with the vast majority of the rule's proposed changes. We recognize the complexity of the LTACH prospective payment system – consistent with the complex care needs of our patient base – and the difficult tasks put to CMS' staff to ensure a fair and proper payment structure and reimbursement system. We recognize the important role that the Administrator plays in being a "good steward" of the federal budget and ensuring that, in all care settings, the appropriate patient is receiving the most appropriate care for the appropriate payment. We believe ALTHA-member hospitals fit that mold well and we hope to work with CMS to meet these and other goals.

## 1) Review of MedPAC's Recommendations

### a. Overview

In order to ensure proper payment for proper care, and in response to the June 2004 report of the Medicare Payment Advisory Commission (MedPAC) recommending that the Secretary consider defining LTACH by facility and patient criteria, CMS has awarded a contract to Research Triangle Institute International (RTI). The rule states that RTI will conduct "a thorough examination of the Commission's recommendations based on the performance of a wide variety of analytic tools using CMS data files and also utilizing information collected from physicians, providers and LTCH trade associations." The study will also examine the present role of quality improvement organizations (QIOs) by focusing on their responsibility regarding the LTCH prospective payment system (PPS) and the potential for an expanded QIO role as recommended by the Commission.

MedPAC's overall objective is to establish criteria that clearly distinguish the LTACH level of care from other treatment settings, by establishing both facility and patient criteria for LTACHs that differentiate their type and level of care and types of patients appropriate for such care. Consistent with Medicare's goals for all treatment settings, MedPAC is recommending that, in the future, payments be tied to improvements in quality of care and maintenance of high quality care. We believe the goal of clearly distinguishing LTACH facilities, treatment, and patients is good health care policy. MedPAC's recommendation specifies that LTACH designation should be limited to the medically complex patient population. Many of the criteria recommended by MedPAC are already met by the vast majority LTACHs as a result of their hospital level of care and the medical complexity of their patient populations.

ALTHA believes that specific criteria should be carefully considered and based on patient clinical treatment requirements and practices. We believe all LTACHs should meet specific criteria to ensure they can provide the resource-intensive and specialized services LTACH patients need. As a trade association representing roughly two-thirds of the entire LTACH industry, ALTHA is well-positioned and eager to assist in this project in any way possible.

In fact, several leading ALTHA-member companies are working collaboratively on an evaluative study of the LTACH provider community with a focus on patient and facility level characteristics. This work has found that a set of LTACH certification criteria should be centered on three main categories:

- **Patient Characteristics.** LTACH criteria should encourage LTACHs to serve a medically complex patient population. The majority of LTACH patients should have multiple co-morbid conditions that complicate their primary diagnosis. There are two relevant proxies for measuring and monitoring this medical complexity:
  - *Retain the current requirement for a 25-day average length of stay for Medicare beneficiaries.* The 25-day length of stay requirement is one reasonable proxy for medically complex care provided to patients who often need long hospital stays as part of their treatment; and
  - *Create a new severity of illness threshold.* At least 50 percent of every hospital's Medicare discharges during its cost report year would be classified into either severity of illness level (SOI) three or four. The severity of illness level is based on the 3M APR-DRG classification system and would require that every facility use this grouper software to ensure that, over a year, at least half of their Medicare discharges are classified in SOI three or four.

- **Structure.** The second LTACH certification criterion should be aimed at ensuring that the facility is organized and operated to support the complex care required for its patients. Currently, major LTACH providers are licensed as acute care hospitals, receive JCAHO accreditation, and meet CMS' hospital conditions of participation. While these quality monitoring mechanisms are important, more requirements are necessary to ensure that LTACHs have the capability to meet the unique needs of the medically complex LTACH patient population. Long-term acute care hospitals should have criteria that require them to have structural elements in place to deliver the appropriate care (e.g., daily physician contacts, availability of respiratory therapy, and interdisciplinary team assessments).
- **Admissions and Continued Stay.** The third criterion for LTACH certification should ensure that admissions and continued stay standards are in place so that LTACHs serve the most medically complex patients. The implementing regulations for the LTACH prospective payment system (PPS) direct the QIOs to perform greater oversight of LTACH utilization assessment and medical necessity review process (42 CFR412.508(a)). The certification criteria should specify that QIO review be based on a nationally uniform set of admissions and continuing stay criteria.

These certification criteria are very similar to those recommended by MedPAC. The study that will begin this spring will attempt to examine these criteria and MedPAC's more closely. We hope the results from this study can contribute meaningful information and data to future policy discussions regarding LTACH certification criteria.

#### b. Recommendations

ALTHA strongly supports the development of LTACH certification criteria using facility and patient characteristics. We believe research findings from the CMS/RTI research study of the LTACH provider community will be a significant aid in developing new LTACH certification criteria. ALTHA requests that CMS consider the findings from the above-mentioned evaluation of LTACH provider community characteristics and practices in conjunction with the RTI study.

In the absence of a formal technical expert panel, CMS should require RTI to work openly and collaboratively with the LTACH provider community in developing new certification criteria. Unlike inpatient hospitals or nursing facilities, there is little publicly available data providing information about LTACH patient outcomes and quality improvement activities. The LTACH provider community does have this data and RTI should work collaboratively with the community to obtain the best data possible. This is imperative for the successful development of certification criteria that reflect LTACH care. MedPAC has recognized this lack of publicly available LTACH data as well and acknowledges the need for close coordination with the LTACH provider community. A collaborative effort will provide the most accurate data and information about this provider group.

## 2) Quality Measures

### a. Overview

CMS states in the proposed rule that it currently does not require LTACHs to submit any clinical or other quality data. CMS is considering what additional data would be required for developing clinical quality measures for LTACHs and is currently evaluating whether CMS' Quality Measurement and Health Assessment Group should develop a quality measurement program for LTACHs. In the proposed rule, CMS stated quality measurement domains for LTACHs should reach a broad population, be based on medical evidence, be scientifically valid, and be actionable. In addition, CMS stated it would consider

measures that cut across other care delivery sites and focus on areas such as medication management or patient safety.

*b. Recommendations*

ALTHA strongly supports CMS' proposal to develop a quality measurement program for LTACHs and encourages CMS to develop these measures in partnership with the LTACH provider community. We suggest an expert panel be formed to oversee and guide the development of quality measures for LTACHs. This panel should include physicians and other LTACH professionals, such as respiratory therapists. In addition, we recommend that CMS establish an LTACH-specific quality initiative to employ these new quality measures. We encourage CMS to consider an initiative similar to the Hospital Quality Initiative where hospitals are given a financial incentive (0.4% higher annual payment update) for reporting quality measures. The development of an LTACH quality initiative should be done in cooperation with the LTACH provider community, the Federation of American Hospitals, and ALTHA to ensure that measures are appropriately risk-adjusted and can be used to improve quality over time.

We thank you for the opportunity to present our views. Please do not hesitate to contact us if you have any questions or comments.

Sincerely,

A handwritten signature in black ink, appearing to read "J. B. Traverse", with a long horizontal flourish extending to the right.

Brad Traverse  
Executive Director