A L C Healthcare Network, Inc. *Creating innovative administrative, clinical and fiscal solutions for healthcare providers*
Morrie Maple, Director New Business Development

February 5, 2007

CMS-1529-P
Department of HHS
P.O. Box 805
Baltimore, MD 21244-8015

Dear CMS Director:

Long Term Acute Care Hospitals are a necessary part in the continuum of post-acute care. These hospitals provide patients a specialized level of care not offered in other post acute settings.

For the past several years many legislative changes have focused on reimbursement to LTAC hospitals. Now there is movement to limit admissions to these much needed hospitals using geographic restrictions. That is, free-standing LTAC's could not admit more than 25% of its patients from one referral hospital. This creates unnecessary burdens on patients, families and the LTAC Hospitals in a community. I do not believe geography should be the regulatory criteria for patient admission.

Just imagine if you had a family member needing the services of an LTAC. If the area LTAC had already admitted 25% of its patients from that facility, and your family member had to be admitted to an LTAC 50-100 miles away, what is the medical and psychological impact on the families, patients and overall continuity of the physician-patient relationship?

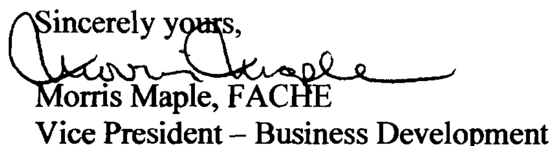
There are two pieces of legislation being reviewed in the House and Senate. The House Bill is H.R. 562, sponsored by Phil English (R-PA) and Earl Pomeroy (D-ND). The Senate Bill is S. 338, sponsored by Kent Conrad (D-ND) and Orrin Hatch (R-UT).

Both of these bills would establish certification criteria for LTAC hospitals. My research on the LTAC industry indicates to me that both pieces of the proposed legislation would ensure that LTAC hospitals would admit and treat only those patients who are medically complex. It also enables LTAC hospitals to expand and meet community needs if high-acuity patients need this level of care.

I urge you to support passage of these two bills. Let's not set an arbitrary criterion that is not in the best interest of patient care.

Thank you for your consideration.

Sincerely yours,



Morris Maple, FACHE
Vice President – Business Development

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CHARLES W. ZADIK, MBA
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January 29, 2007

Department of Health and Human Services
Attention: CMS-1529-P
P.O. Box 8015
Baltimore, MD 21244-8015

Proposed 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.

XII. Payment for Direct Graduate Medical Education (GME).

"PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION"

C. OTHER ISSUES TO BE CONSIDERED

Using Example 1 for the calculation of the 90 Percent Cost Threshold, the hospital is incurring all or substantially of the cost by meeting the 90 Percent Cost Threshold. By using the formula as previously indicated in the text, the hospital is meeting the 90 Percent Cost Threshold by only paying the resident's salary and fringe benefits during training at the non hospital site. The payment of the resident's salary and fringe benefits is readily identifiable and verifiable by Medicare Contractors by reviewing the hospital's financial records. In addition there maybe other non provider sites where this circumstance may occur, including sole practitioner non provider sites or group practice physicians non provider sites acting as sole practitioners.

As stated in this section of the proposed rule, the hospital would have to calculate the 90 Percent Cost Threshold "upfront" before any rotations took place at the non hospital site. The calculation will indicate whether the hospital incurs all or substantially all of the cost of the rotations to the non hospital site, simply by just paying the intern and resident's salary and fringe benefits. This calculation is also readily verifiable by Medicare Contractors upon audit of the hospital's cost report.

Hospitals who meet the 90 Percent Cost Threshold and incur all or substantially all of the cost for resident rotations to the non hospital site by only paying the salaries and fringe benefits of its intern and residents. These hospitals should <u>not be required</u> to insert in their written agreement with the non hospital site that the hospital will pay all or substantially all of the cost for resident rotations to the non hospital site. Similarly, hospitals should <u>not be required</u> to insert in their written agreement with the non hospital site that the hospital will incur at least 90 percent of the cost of the resident's salary and fringe benefits (and travel and lodging where applicable) while the resident is training in the non hospital site. Lastly, hospitals should <u>not be required</u> to indicate the compensation amount paid as salary and fringe benefits to its residents.

Section 413.78 (f) (3) (ii) can be amended to read as follows:

Section 413.78 (f) (3) (ii) states that a hospital must have a written agreement with the non hospital site. The agreement must state the hospital will incur at least 90 percent of the cost of the resident's salary and fringe benefits (and travel and lodging where applicable) while the resident is training in the non hospital site and the portion of the

cost of the teaching physician's salary is attributable to GME, sole practitioner sites and payment of resident salaries that meet the 90 percent cost threshold are excluded. The written agreement must also specify the compensation amount the hospital is paying the non hospital site, sole practitioner sites and payment of resident salaries that meet the 90 percent cost threshold are excluded, and whether this amount only reflects only resident's salaries and fringe benefits (and travel and lodging is applicable), or includes and amount for teaching physician compensation.

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

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.

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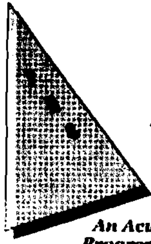


Progressive Healthcare, Inc.

February 12, 2007

Centers or Medicare and Medicaid – 1529-P
Dept HHS
P.O. Box 805
Baltimore, MD 21244-8015

Dear Director:

Long Term Acute Care Hospitals are a necessary part in the continuum of post-acute care. These hospitals provide patients a specialized level of care not offered in other post acute settings.

For the past several years many legislative changes have focused on reimbursement to LTAC hospitals. Now there is movement to limit admissions to these much needed hospitals using geographic restrictions. That is, free-standing LTAC's could not admit more than 25% of its patients from one referral hospital. This creates unnecessary burdens on patients, families and the LTAC Hospitals in a community. I do not believe geography should be the regulatory criteria for patient admission.

Just imagine if you had a family member needing the services of an LTAC. If the area LTAC had already admitted 25% of its patients from that facility, and your family member had to be admitted to an LTAC 50-100 miles away, what is the medical and psychological impact on the families, patients and overall continuity of the physician-patient relationship?

There are two pieces of legislation being reviewed in the House and Senate. The House Bill is H.R. 562, sponsored by Phil English (R-PA) and Earl Pomeroy (D-ND). The Senate Bill is S. 338, sponsored by Kent Conrad (D-ND) and Orrin Hatch (R-UT).

Both of these bills would establish certification criteria for LTAC hospitals. My research on the LTAC industry indicates to me that both pieces of the proposed legislation would ensure that LTAC hospitals would admit and treat only those patients who are medically complex. It also enables LTAC hospitals to expand and meet community needs if high-acuity patients need this level of care.

I urge you to support passage of these two bills. Let's not set an arbitrary criterion that is not in the best interest of patient care.

Thank you for your consideration.

Sincerely yours,

Morrie Maple, FACHE
Vice President – Business Development

6

TEXAS HEALTH RESOURCES

March 19, 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:

On behalf of Texas Health Resources (THR) and its 13 faith-based, nonprofit community hospitals throughout north Texas, including Harris Methodist Hospitals, Arlington Memorial Hospital and Presbyterian Healthcare System, we appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule that seeks to make significant changes to the admission practices of long-term care hospitals (LTCHs) as well as payment policies. We urge CMS not to expand the 25% rule to freestanding and grandfathered hospitals and to reject the extreme SSO policy under consideration.

Harris Methodist Continued Care Hospital (HCCH) in Fort Worth, Texas, serves a significant percentage of Medicare patients residing in north Texas. 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 HCCH in fiscal year 2008, forcing the hospital to operate at a loss when treating Medicare patients. HCCH 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 HCCH and the patients and communities it serves will be placed in jeopardy if they are adopted.

In the preamble to the updated 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' 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.

THR and HCCH question 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.

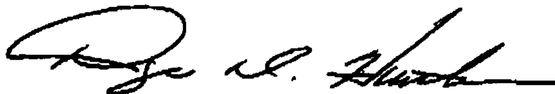
The proposed SSO rule is an unprecedented intrusion on physician decision making and contrary to long standing Medicare principles that govern medical necessity determinations. It would impose a payment adjustment as a mechanism to disqualify a patient for hospital services and intrude upon a physician's 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, THR and HCCH respectfully request that CMS not expand the 25% rule to freestanding and grandfathered hospitals and that it reject the extreme SSO policy under consideration.

Thank you for the opportunity to share our comments. If we can provide you or your staff with additional information, please do not hesitate to contact Joel Ballew, Director of Government Affairs, at 817-462-6794 or by e-mail at JoelBallew@TexasHealth.org.

Sincerely,



Douglas D. Hawthorne, FACHE
President and CEO
Texas Health Resources

7

March 16, 2007

The Honorable Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1529-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: ***Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008***

Dear Ms. Norwalk:

I would like to share with you my personal experiences with care at a long term acute care (LTAC) hospital and ask that you Not implement the Proposed Rule, at least not the 25% admission rule criteria.

My mother had an obstructed bowel section removed in surgery in 2001. The surgeon gave her a 50/50% chance of survival. After stabilization in the hospital, she was transferred to an LTAC hospital. The medical treatment and personal care she received in the LTAC hospital was truly outstanding. Had she not been admitted to the LTAC hospital, she probably would have died within weeks. Although she became septic and died 6 months later, the LTAC hospital helped her recover from the surgery. The last 6 months of her life was truly a blessed time, and the care she received at the LTAC hospital was the reason we had that time.

In 2003, my 80 year old mother-in-law fell while boarding a plane from the tarmac in Chicago O'Hare airport and broke C-1 and C-2 in her neck. Although this is normally a death sentence, the surgeons at Northwestern University Hospital performed successful surgery. After 6 weeks of recovery, she was transported home and, after a short stay in a general hospital, was transferred at our request to the same LTAC hospital my mother had been in. If mother-in-law had gone to a different LTAC hospital, because of the proposed 25% rule, it would have been a hardship on our family because of distance, familiarity, and getting to know and trust different doctors. She was still in a fragile state, with a high risk of dying. Once again, because of the great care she received at the LTAC hospital, her outcome was good. She is now 84 and living a normal (for an 84 year old that had neck surgery) life.

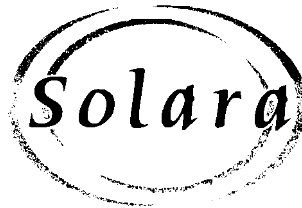
As you can see, my first hand experience with LTAC hospitals shows that they have great value in our healthcare system. Please do not make harmful changes to rules and reimbursement for LTAC hospitals. Please do not implement the 25% admission quota and take away patient choice. Also, please do not reduce reimbursement and reduce the quality of care LTAC hospitals can provide.

I hope that you leave LTAC hospital rules alone so that all Americans will have access to these wonderful institutions if they need them.

Sincerely,

Pam and Ken Ross
1310 Bentley Ct.
Southlake, TX 76092

8



March 16, 2007

The Honorable Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1529-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: ***Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 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:

I have serious concerns about the proposed "long term acute care" (LTAC) hospitals regulation the Centers for Medicare and Medicaid Services (CMS) published on January 25th, 2007, that introduces significant changes to the way LTAC hospitals are reimbursed by Medicare. While I understand CMS has concerns about the number of LTAC hospitals, an arbitrary admission quota is not a good answer. The use of clinical admission criteria, as included in legislation introduced in both the U.S. Senate and House of Representatives, is a much more appropriate way to ensure only appropriate patients are treated in LTAC hospitals. CMS' proposal is full of inequity, especially for smaller cities that have only a few general hospitals. Local LTACH care should not be restricted to only a few very large cities.

Solara Healthcare (Solara) is a long term acute care hospital company that owns and operates LTAC Hospitals in Shawnee and Muskogee, Oklahoma, and McAllen and Harlingen, Texas. Two hospitals are under construction in Brownsville, Texas, and Conroe, Texas, and are planned to open in 2007. The proposed rule by CMS will cause serious harm to Solara's patients, hospitals, and company. The following items are presented to briefly describe some of the harmful impact the new rule will have, if enacted:

1. Muskogee, OK

There is only one general hospital in Muskogee – the 25 (or 50% for rural or Medicare dominate hospitals) admission limitation from the one hospital does not even begin to work in a one hospital city. Although this rule sounds like an LTAC can fill 25% (or 50%) of its beds with admissions from one hospital, in reality the LTAC can only admit one patient from the local hospital for every 3 (or 1 in the 50% situation) that it admits from somewhere other than the local hospital. Therefore,

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for every admission from somewhere other than Muskogee Regional Medical Center (MRMC), the LTACH could admit one patient from MRMC. For example, in a month's time if there are 4 patients needing LTACH care wanting to come back to Muskogee from a Tulsa hospital, the LTACH could also admit 4 patients from MRMC. This would result in a total of eight admissions in a month for this 41 bed hospital, and would result in:

a. Bankruptcy of the LTAC hospital is likely; it could not cover its rent and other costs with such few patients.
b. If the LTACH survived, many patients in Muskogee appropriate for LTACH care would not be able to receive LTACH care in Muskogee, even though there would be empty LTACH beds.
c. Loss of approximately 150 jobs in the community.
d. Solara Healthcare's 15 year guarantee of the lease of approximately $1 million per year rental payments would put the existence of Solara Healthcare at risk of bankruptcy.
e. Patients needing LTAC hospitalization would have to go to Tulsa for admission, probably by ambulance. These patients are fragile and a long ambulance ride is difficult for them. The ambulance would be tied up with the transfer and would not be available for other emergencies.
f. Family members would have to make the drive to Tulsa to see their loved ones, and many try to visit daily. With an average stay of 25+ days, the burden on families is heavy.

2. <u>Harlingen and Brownsville, TX</u>
There are two general hospitals in Harlingen and two hospitals in Brownsville. Both cities are in the same MSA.

a. Under the 25% rule, the Brownsville LTACH would only be able to admit 50% of its patients from Brownsville hospitals. A similar situation would exist in Harlingen.
b. 50% of the patients in Harlingen and Brownsville would have to travel elsewhere to receive LTACH care.
c. Ambulances would be criss-crossing between cities, putting a burden on the patient, the family, the LTAC hospitals, and the ambulance services.
d. These buildings were built by developers that required guarantees by Solara. The rent for each is approximately $1 million per year. If the LTACHs fail because of the 25% rule, Solara Healthcare's existence would also be in jeopardy.

3. <u>Conroe, TX</u>
There are several LTACHs in North Houston and the Woodlands, TX.

a. The majority of patients needing LTACH care in Conroe would have to go to the Woodlands or North Houston.
b. They would drive past the Solara LTACH in Conroe, with empty beds.
c. They would not be able to be treated by their same doctor in Conroe, but would have to be assigned a doctor who works in North Houston or the Woodlands.

For the Conroe LTACH to survive, it would have to admit 75% of its patients from the Woodlands, North Houston, and other areas, while refusing admission to Conroe patients needing LTAC care and wishing to stay in Conroe.

My additional comments on the proposed rule are summarized in the following paragraphs:

A. "OTHER PROPOSED POLICY CHANGES FOR THE 2008 LTCH PPS RATE YEAR"

Proposed Extension of 25% Patient Quota Rule to Freestanding LTAC hospitals. CMS proposes a payment penalty for freestanding LTAC hospitals for every patient over a 25% threshold that comes from any single acute care hospital referral source. In addition, CMS proposes to revoke "grandfather" status from certain "Hospital within Hospital" LTAC hospitals that have been exempt from this rule. The proposed regulation would limit the way patients are referred to LTAC hospitals, an LTAC hospital could not have more than 25% of its patients referred from any one general hospital. I would like to comment on some of the harmful impact to patients and LTAC hospitals the regulation would cause, as well as better options to achieve the same goals:

1. With respect to the proposed rule, the Medicare Payment Advisory Commission (MedPAC) has noted that these referral quotas are a rather crude and unsophisticated approach to dealing with hospital admissions. No other Medicare-reimbursed facility has to deal with such draconian policies. These admission quota limits – which even MedPAC says are arbitrary -- ignore the clinical and quality of care considerations that should be the primary determinant of access to LTAC hospital care.

2. It has been almost three years since MedPAC called for CMS to create certification criteria to address the growth of the number of LTAC hospitals. Instead of imposing a crude and unfair quota rationing system, CMS should develop certification criteria for America's LTAC hospitals.

3. Late last year, CMS received a report from RTI that it commissioned regarding LTAC hospital certification criteria. The RTI study was generally positive for the LTAC hospital industry, conclusively acknowledging that LTAC hospitals play a legitimate and constructive role in the continuum of American healthcare services. This proposed CMS quota rule pays little heed to the RTI study which CMS commissioned and funded. The proposed quota rule will cause many LTAC hospitals to close, especially in underserved and rural areas which have only one or two general hospitals.

4. In the face of several years of regulatory delays, a number of Members of Congress sponsored legislation to address the criteria issue for LTAC hospitals. In the U.S. Senate, Sen. Kent Conrad and Sen. Orrin Hatch introduced S. 338. In the U.S. House, Rep. Earl Pomeroy (D-ND) and Rep. Phil English (R-PA) sponsored a similar bill, H.R. 562. These bills would establish criteria to define what an LTAC hospital is and which patients should be treated there. They would limit the type of patients who can be treated in an LTAC hospital and reduce Medicare spending on LTAC hospitals by $1-2 billion over five years. These bills present a rational way to limit spending on LTAC hospitals, as opposed to the 25% rule that will create unnecessary and uneven hardships for patients and hospitals.

5. A few more examples of harm the 25% rule proposal would cause include:
   - Loss of local LTACH services in all but large metropolitan areas
   - Fragile patients would have long ambulance rides to access LTACH care
   - Families of patients would have long drives to see loved ones in LTAC Hospitals, for over 25 days average hospitalization
   - Patients would have to drive past LTAC hospitals with empty beds in their community and drive to another city to get LTAC care, because of the quotas
   - The 25% quota does not work in Cities with only 1 or 2 acute care hospitals. There is no place for the first 25% of patients to come from, before the matching 25% from the local hospital can be admitted.
   - Constant CMS changes lead to healthcare industry instability
   - The constant annual changing of regulations and reimbursement hurts small businesses that are trying to build long term companies that provide quality healthcare services to very ill patients. Companies cannot plan for the future when CMS significantly changes the regulations every year.
   - Capital commitments have been made by companies to build new hospitals; the 25% rule could cause bankruptcies caused by the inability to service lease payments and guaranties that were required to get the new hospitals built.

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. These policies discriminate against patients in the 26th percentile and higher and patient care will suffer.

The affect of the existing 25% rule and other changes made over the last three years have not been fully documented yet and CMS does not yet have data to confirm that the policy is achieving the stated policy goals and not having adverse effects on patient care. The proposed 25% rule expansion is a draconian quota system that would cause the most harm to patients and LTACHs in rural and underserved areas. This proposal should be dropped, if not for all free-standing LTACHs, at least for areas that have less than 4 equivalent STAC hospitals.

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. In addition, the same rationale for creating grandfathered status for PPS-exempt hospitals that were established before the HIH regulations took effect holds true for freestanding LTACHs under the current proposal to extend the 25% rule to them. If CMS finalizes this policy in spite of strong congressional and industry opposition, all existing and under-development freestanding LTACHs should be grandfathered from compliance with the new rule.

We plead that CMS will consider and decide the following:

1. Not implement a 25% admission limit, if not for all free-standing LTACHS, at least for rural, underserved, and other areas with less than four equivalent sized general hospitals; or
2. If the 25% rule for free-standing hospitals is implemented, permanently grandfather existing LTACHs and hospitals currently being constructed to become LTACHs.

This would provide sensible governing:

- Companies that have invested in and guaranteed long term hospital leases, based on the rules in existence, would have a chance to survive and meet their obligations.
- Appropriate LTACH patients could receive care in their home town, or closer to home, if an LTAC Hospital is already there.
- Patients could be treated by their own doctor, instead of getting a new doctor in the town they have to travel to.
- Families could visit their loved one daily without an extra burden of travel, lodging, meals and other expense and burden.

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

1. ***Overall Payment Adequacy.*** The Medicare Payment Advisory Commission (MedPAC) found that LTAC hospital margins are between 0.1% and 1.9% (MedPAC Report to Congress, March 2007). Yet, CMS projects the proposed rule would reduce payments by 2.9%, which results in rates below the cost of care. In addition, CMS's estimate understates the actual impact by approximately 0.9% because it fails to account for the negative impact of raising the high cost outlier threshold by $3,887 per case. CMS should not propose LTAC hospital rates that fall below the cost of care. The proposed rates are not reasonable nor adequate given Medicare's goal of covering providers' cost of care. Furthermore, payments would be reduced by a much greater percentage for LTACHs serving rural and underserved areas that have less than at least three or four general hospitals.

2. ***Short Stay Outlier Payment Adjustment.*** CMS also proposes to pay LTAC hospitals a reduced rate for "very short stay" outlier cases. CMS again justifies this proposal based on the concern that Medicare should not pay twice for a single episode of care. Less than one year ago, CMS finalized a rule that pays LTAC hospitals no greater than cost for all short stay outlier cases. It is too soon to implement further payment adjustments when the new policy has been in effect for less than one year and the impact has not been assessed. LTAC hospitals have no incentives to admit patients that will be "short stay" when LTAC hospitals are already paid no greater than cost for these patients.

3. ***Market Basket Update.*** CMS proposes paying LTAC hospitals a 0.71% market basket update, less than the full market basket update of 3.2%, which represents an estimate of actual cost increases experienced by LTAC hospitals. CMS should provide the full market basket increase, especially in light of other payment adjustments, or the cumulative effect of the proposals results in LTAC hospital rates below the cost of care. Nurse and other staff, supplies, and drug costs continue to increase faster than inflation.

4. ***LTAC Hospital Certification Criteria***. Legislation has been introduced in the Senate (S. 338) and House (HR 562) to revise LTAC hospital certification criteria to implement MedPAC recommendations of over two years ago. Congress has made it clear that revised LTAC hospital certification criteria, not continued payment cuts, is the preferred policy route to address issues of concern. The proposed rule continues a pattern of arbitrary and punitive payment cuts, based upon questionable assumptions and incomplete or outdated data, which will hurt LTACHs and Medicare beneficiaries. An approach that would better serve Medicare beneficiaries would be to work together with the LTACH industry and the Congress to develop new certification criteria to better define LTACH facilities and patients to accomplish this goal and help stabilize Medicare reimbursement to LTACHs.

5. ***LTAC Hospital Growth***. CMS continues to raise concerns about growth in the number of LTAC hospitals. However, the cumulative effect of CMS's recent changes and existing payment policies have halted, and possibly reversed, the growth of new LTACHs, and LTACH margins are estimated by MedPAC to be at or near zero. Growth in the number of new LTACHs has stopped.

6. ***CMS is interfering with patient choice and the practice of medicine.*** The proposed rule greatly restricts patient choice and interferes with the practice of medicine by arbitrarily paying LTACHs at the LTACH payment rate for no more than 25% of its patients referred from any one hospital. This policy also violates the agency's own stated goal to place Medicare patients in the most appropriate post-acute care setting. CMS should implement an LTACH PPS that recognizes the medically complex care LTACHs provide and the will of Congress to fairly pay for LTACH services. The Congress, the LTACH industry, MedPAC, and RTI International (which recently provided a report to CMS on LTACHs) all agree that LTACHs serve an important role in caring for medically complex patients who need long-term hospital stays. The combined effect of this proposed rule makes clear that CMS does not agree with this most basic premise. These proposed policies will continue to erode the LTACH PPS by reimbursing LTACHs for fewer and fewer medically complex patients at the LTACH PPS rates.

7. CMS must implement an LTACH PPS that fairly reimburses LTACHs for the costs they incur in caring for Medicare beneficiaries, in keeping with the statutory mandate of Congress. The proposed changes to the regulations will bring LTACH reimbursement below their cost of care.

Conclusion

The 25% admission from any one hospital policy will have a disparate impact on LTACHs in areas without at least four equivalent referral hospitals – primarily underserved, rural and other nonurban markets – that is not appropriately accounted for with the limited number of exceptions to the 25% rule. CMS should not extend the current 25% rule, or any similar policy, to freestanding LTACHs or grandfathered LTACHs. However, if CMS finalizes this policy, it should:

(1) Grandfather all existing and under-development freestanding LTAC hospitals from the rule altogether, and

(2) Set the applicable percentage for all new freestanding LTACHs at 50% in light of the lesser policy concerns CMS has with these hospitals as compared to co-located LTACHs, and
(3) Exclude rural areas and other cities with less than 4 equivalent hospitals from the 25% rule.

Thank you for your attention to the important considerations related to LTAC hospitals raised in this letter.

Sincerely,

Kenneth R. Ross, CHE
Chief Executive Officer

The Model for the Relief of Cancer Pain and Symptoms for Over a Century

9

Office of the President

March 13, 2007

VIA EXPRESS MAIL
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: 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 Administrator Norwalk:

The Calvary Hospital ("Calvary") welcomes the opportunity to submit these comments on proposed rules published on February 1, 2007 at 72 *Fed.. Reg.* 4776 *et seq.* Calvary appreciates the consideration and thoughtful analysis CMS has provided in its proposal to exclude subclause II LTCHs and satellites of subclause II LTCHs from the proposed changes to the short stay outlier policy and the expansion of the so-called 25% rule (proposed 42 C.F.R. § 412.536) to freestanding long-term care hospitals (LTCHs).

1740 Eastchester Road, Bronx, NY 10461 Tel: 718-518-2244 Fax: 718-518-2674
fcalamari@calvaryhospital.org www.calvaryhospital.org

Other Proposed Policy Changes for the 2008 LTCH PPS Rate Year

Calvary Hospital is in agreement with, and supports CMS' position that, the proposed changes with respect to short stay outliers (SSOs) would not be appropriate to apply to Calvary Hospital because of the uniqueness of the services it provides. Calvary Hospital is singular in its mission as the only hospital in the United States dedicated exclusively to providing medical care and treatment to advanced long stay cancer patients. Congress has recognized the uniqueness of Calvary by not applying the greater than 25 day average length of stay (ALOS) requirement generally applicable to LTCHs to Calvary. Instead, the Calvary Hospital is defined under Section 1886(d)(1)(B)(iv)(II) of the Social Security Act as:

> "a hospital that first received payment under this subsection in 1986 which has an average inpatient length of stay (as determined by the Secretary) of greater than 20 days and that has 80 percent or more of its annual Medicare inpatient discharges with a principal diagnosis that reflects a finding of neoplastic disease in the 12 month cost reporting period ending in fiscal year 1997."

As CMS has acknowledged in prior rulemaking, over half of the patients treated at Calvary would qualify as short-stay outliers by virtue of the Hospital's unique Congressional mandate. See, e.g., 68 *Fed. Reg.* 34122, 34147 (June 6, 2003). It would therefore be inequitable to apply the proposed changes in the SSO policy to Calvary. We agree with CMS' position to exclude Calvary from the proposed changes to the SSO policy.

We also agree with CMS' proposal to exempt Calvary Hospital from the proposed changes to 42 C.F.R. §§ 412.534(h) and 412.536 (the 25% rule) for the reasons stated by CMS at 72 *Fed. Reg.* 4814-4815. As CMS notes while the ALOS calculation for a subclause I LTCH is based on a calculation of the percent of Medicare discharges, the ALOS for a subclause II LTCH such as Calvary Hospital is based on total discharges

(Medicare and non-Medicare). Therefore, applying a payment adjustment such as the 25% rule that is based solely on Medicare discharges to a subclause II LTCH such as Calvary, is not appropriate. Furthermore, as CMS explains, it is also consistent with CMS' policy to exclude satellites of subclause II LTCHs from the proposed changes to the 25% rule. 72 *Fed. Reg.* 4815.

Calvary Hospital endorses and supports CMS' proposal to exclude subclause II LTCHs and satellites of subclause II LTCHs from the proposed changes to the short stay outlier policy and the 25% rule. Calvary Hospital thanks you for your consideration of these comments.

Sincerely,

Frank A. Calamari
President/CEO

National Government Services, Inc.
400 South Salina Street
Syracuse, New York 13202
A CMS Contracted Agent

10

Medicare

888-855-4356

March 9, 2007

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

Ref: CMS-1529-P

Dear Sir/Madam:

We reviewed the Federal Register of February 1, 2007 regarding the Proposed Rule: Medicare Program: Prospective Payment System for Long-Term Care Hospitals RY 2008 and offer the following comment:

The effective date for the proposed GME/IME regulations should be effective for cost reporting periods beginning on and after July 1, 2007.

Thank you for the opportunity to comment.

Sincerely,

Lloyd Kasow
Medicare Coordination

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

St. Francis • Specialty Hospital

11

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:

St. Francis 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.

St. Francis Specialty Hospital was established on July 1, 1995 and is located at 309 Jackson Street, Monroe, Louisiana. It serves a significant percentage of Medicare patients residing in the Northeast Louisiana and Southeast Arkansas 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. The two proposals would drastically reduce payments to St. Francis Specialty Hospital in fiscal year 2008 by approximately 32 percent, forcing St. Francis Specialty Hospital to operate at a loss when treating Medicare patients. St. Francis Specialty 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 St. Francis Specialty 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

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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.

St. Francis Specialty 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 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.

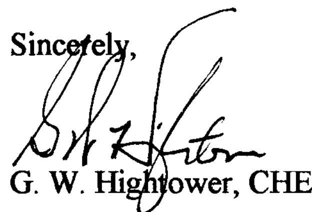
CMS also disregards the fact that a percentage of SSO cases are crossover cases that exhaust Medicare Part A benefits during their LTCH stay. It would be unfair to preclude these Medicare recipients from admission to an LTCH simply based on the number of their remaining Medicare days.

The proposed SSO rule is an 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).

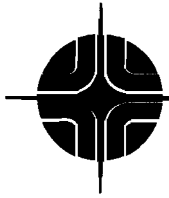
In view of the foregoing St. Francis Specialty Hospital respectfully requests that CMS not expand the 25% rule to freestanding and grandfathered hospitals, and that it reject the extreme SSO policy under consideration.

Sincerely,



G. W. Hightower, CHE

President & Chief Executive Officer



Ephraim McDowell Health

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March 5, 2007

Tzvi Hefter, Director
Division of Acute Care Hospital and Ambulatory Policy Group
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1529-P
P.O. Box 8015
Baltimore, MD 21244-8015

Re: Comments to 2008 Proposed Changes to LTACH Prospective Payment System

Greetings:

On behalf of Ephraim McDowell Health ("Ephraim"), please accept these comments to the Centers for Medicare and Medicaid Services' ("CMS") "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" (hereinafter "Proposed Rule").

Ephraim is an integrated health care system serving nearly 150,000 residents of Central Kentucky. The Ephraim system is developing a freestanding long term acute care hospital ("LTACH") within Kentucky and opposes the Proposed Rule as it relates to the imposition of a limit on the number of patients a freestanding LTACH may accept from any one referral source (the "25% Threshold Rule"). The Proposed Rule, in Section (V)(B), contains a provision that extends to freestanding LTACHs the special payment provisions currently being phased-in for LTACH Hospitals-within-Hospitals and Satellites. The provision arbitrarily reimburses LTACHs under the short-term prospective payment system if they admit greater than 25% of their patients from a single source. The payment adjustment applies to those patients beyond the 25% threshold.

For the following reasons, Ephraim respectfully requests CMS remove this provision from the Proposed Rule:

217 South Third Street • Danville, KY 40422 • Tel (859)239-1000 • Fax (859)239-6960 • www.emrmc.org

1) **Extending the 25% Threshold Rule to freestanding LTACHs does not promote patient quality of care, but impedes it.**
   - The United States Congress introduced LTACHs into the healthcare continuum to alleviate the overutilization of short-term acute beds for medically complex patients with a longer length of stay. LTACHs treat the nation's sickest patients, which require an average hospital stay of 25 days. The Proposed Rule contradicts Congress' intent by forcing LTACHs to focus on the quantity, rather than quality, of referral sources.
   - The Proposed Rule arbitrarily requires a freestanding LTACH to, in essence, have more than four referral sources. Even if an LTACH has five or more referral sources, the largest one may still send more than 25% of patients to the LTACH.
   - Multiple referral sources decrease an LTACH's ability to control short stay outliers and manage hospital-acquired infections. It is undisputed that an LTACH has greater success identifying and treating infections when there is consistency in the origin of the infection. Treating infections from a half-dozen venues produces a health care facility vulnerable to increased infection rates.
   - Forcing venue diversity hinders the development of relationships between LTACH physicians and the referral facilities, which negatively impacts the complexity of communication necessary for quality healthcare.
   - The Proposed Rule encourages LTACHs to focus on the minutiae of not admitting greater than 25% of their patients from a single source, rather than identifying patients in need of long-term hospital care in an acute setting.

2) **No other post acute care venue mandates a location-based referral methodology.**
   - Requiring LTACHs to limit referrals is illogical. There are no limits on referral sources for inpatient rehabilitation facilities, skilled nursing facilities, hospices, home health or others. LTACHs admit and discharge patients from large health systems in the same fashion as a rehabilitation unit or skilled nursing facility, which discredits CMS' singling out LTACHs' referral bases.

3) **The 50% Threshold Rule is inappropriate in rural areas.**
   - The allowance of a 50% Threshold Rule for rural and MSA-dominant LTACHs fails to remedy the disastrous effects of the Proposed Rule when a second or third viable referral source is often 50 to 100 miles away.
   - The 50% Threshold Rule's applicability to freestanding LTACHs would devastate isolated short term acute hospitals in need of a discharge destination for medically-complex, high acuity long-term patients. There are only a handful of LTACHs in Kentucky. If we cannot refer to one LTACH, our patients may require ambulance transport to another LTACH several hours away.

4) The 25% Threshold Rule is detrimental to short-term acute care hospitals in need of a discharge destination for long-term care patients.

- This Rule would override physician decision-making as to the appropriate placement of patients for medically necessary care. On page 203, the Proposed Rule notes that in the Balance Budget Act of 1997 Congress intended to discourage acute care hospitals from prematurely discharging patients to another treatment setting in order to increase Medicare payment. The 25% rule effectively prioritizes reimbursement concerns over a medical determination of the necessity for LTACH programs of care.
- Without LTACH beds available to a hospital, bed-turnover will continue to be impeded and the ability of the hospital to treat patients in need of short-term care will be restricted.

The Ephraim McDowell Health system strongly opposes the application of the 25% or 50% Threshold Rules to freestanding LTACHs and implores CMS to reconsider this provision.

Thank you for your consideration of this request.

Sincerely,

Ephraim McDowell Health, Inc.

By: ______________________
L. Clark Taylor, Jr., CEO

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Health Alliance

Executive Offices
3200 Burnet Avenue
Cincinnati, OH 45229
513-585-6000

March 2, 2007

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

Re: Other Proposed Policy Changes For The 2008 LTCH PPS Rate Year

Dear Administrator Norwalk:

Thank you for giving me the opportunity to offer comments on this tremendously important matter of public policy. I write specifically in reference to part B, which outlines CMS's proposal to extend the 25 percent rule to freestanding, long-term care hospitals. Extending this rule would have a devastating impact on The Drake Center, a long-term care hospital that serves the post-acute care needs of Southwest Ohio, Northern Kentucky and Southeast Indiana.

The Drake Center is a member of the Health Alliance, a system of seven community-based, not-for-profit hospitals that serve the same aforementioned geographic area. Drake Center had a long and distinguished record of serving the entire region and had been supported for decades by a community-approved tax levy. Notwithstanding this support, Drake Center was on the brink of financial ruin.

In December of 2005, the Health Alliance was brought in to begin managing Drake. At that time, the Health Alliance hospitals accounted for approximately 70 percent of Drake Center admissions. In July of last year, the Health Alliance rescued Drake Center by purchasing it from Hamilton County. The Health Alliance has since restructured the hospital's day-to-day operations and finances, thereby dramatically improving the quality of patient care. Drake is now on a path to recovery. Imposing this policy change however would unravel the positive gains that have been made since Drake became a member of the Health Alliance.

For decades Drake has been closely linked to The University Hospital because of their unique service specialties, as teaching facilities for the University of Cincinnati's Medical College, and through research initiatives. This linkage is both appropriate and reasonable given the unique capabilities that both hospitals possess: University Hospital is Cincinnati's only teaching hospital, home to the region's only Level One Trauma Center and the only area hospital to provide a full range of solid organ transplants. University Hospital is also home to The Neuroscience Institute, which attracts neurological patients from throughout the region. (In fact, University Hospital sees nearly 40 percent of the

neuro-trauma cases in a 30-mile radius of Cincinnati.) In a similar vein, Drake is the only long-term care hospital in this region that provides critical services such as advanced wound care, traumatic brain injury rehabilitation, neuromuscular rehabilitation, stroke rehabilitation and spinal cord injury rehabilitation. Fifty-eight percent of Drake's patients come from University Hospital. Drake however is not a "functional step-down unit" for University Hospital: where University Hospital's skills end in treating medically complex patients, Drake's begin. The referrals from University Hospital are therefore medically appropriate and entirely necessary.

Drake could therefore be fairly characterized as Cincinnati's "MSA (metropolitan statistical area)-dominant LTCH". No such designation exists however under existing or proposed regulations. The University Hospital could also be reasonably described as an "MSA-dominant hospital" given the breadth of its intensive care services that no other Cincinnati-area hospital offers. However, section 412.536(d) simply defines an MSA-dominant hospital" as "a hospital that has discharged more than 25 percent of the total hospital Medicare discharges in the MSA in which the hospital is located." No single hospital in this MSA accounts for 25 percent of the Medicare discharges. (University Hospital accounts for 7 percent of the Medicare discharges in this MSA.)

CMS therefore ought to modify its proposed regulations to recognize the unique capabilities that many community-based, long-term care hospitals possess and the logical linkages that they frequently have to large, urban-based, acute-care hospitals that offer intensive care services. In this case, Drake is the sole provider of critical services that compliment the critical (and distinct) services found at The University Hospital.

Thank you for giving me the opportunity to provide comment on this matter. If you have any questions or need clarification, please do not hesitate to contact me at 513-585-8815.

Sincerely,

Tony Condia
Vice President, Government Relations

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Council Members

Chair
David Bjorkman

Members
John Berneike

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Larry Reimer

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Chair:

Physician
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Utah Medical Education Council
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March 9, 2007

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: PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION (42 CFR §413.79)

The Utah Medical Education Council is an organization with representation from all of the graduate medical education program sponsors and teaching hospitals for the State of Utah. We are responding to CMS' February 1, 2007 proposed rule regarding resident training in non-hospital settings. Our comments address the following topics:

- Recognition of volunteer faculty.
- Proposed revisions to the definition of "all or substantially all" of resident training costs.

Recognition of Volunteer Faculty

We appreciate CMS' efforts to redefine "all or substantially all" of required resident training costs in non-hospital settings. However, we are disappointed that CMS has maintained its stance that volunteer faculty can only exist in the situation where a physician's compensation at the non-hospital site is based solely and directly on the number of patients treated and billed for by the practitioner.

Academic medical centers have worked with volunteer faculty for many years to the benefit of both parties. Negotiation for reimbursement for supervisory costs have been left to the parties involved, as is appropriate. Volunteer faculties receive significant non-monetary benefits from their work with interns, residents

and fellows. Medicare's requirements for the cost calculation of volunteer faculty represent a potential decrease in payment to the training center and/or an increase in overall health care costs without a commensurate benefit to the volunteer. However, CMS has chosen to interpret the statute to require a determination of the cost to the site for teaching physician time spent in medical education activities.

Proposed Revisions to the Definition of "All or Substantially All" of Resident Training Costs

Although we disagree with CMS's interpretation of the volunteer faculty rule, we will cooperate with the use of a 90% threshold for the determination of "all or substantially all" of resident training costs. We like having the option to be able to use proxy data in lieu of actual physician salaries and required time studies, but we would like to see changes to the proposed proxy physician salary data and to the presumptive level of time for supervising physician evaluation and didactic activities. Our recommended revisions to those factors are discussed below.

1. **Proposed Proxy Physician Salary Data**

   Our recommendation is to use the Medicare reasonable compensation equivalent (RCE) limits, as outlined in §1887(a)(2)(B) of the Social Security Act, as the proxy for actual physician salaries instead of national salary compensation from the American Medical Group Association. We believe that there should be some consistency between "allowed" physician compensation on the Medicare cost report and the required physician payments for graduate medical education training.

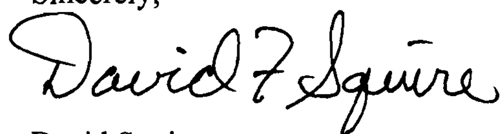
   Moreover, for States like Utah, the use of national salary data does not appropriately recognize that our wage levels are lower than in other geographic areas. Consequently, using unadjusted national salary data really results in a threshold higher than 90% of "all or substantially all" of resident training costs for geographic areas whose physician compensation is lower than the mean or median national salaries.

2. **Presumptive Level of Time for Supervising Physician Evaluation and Didactic Activities**

   Based on the experience of our residency programs, the proposed 3 hour presumptive level of time for supervising physician evaluation and didactic activities is too high. The vast majority of resident training time in non-hospital settings is spent seeing actual patients. As a result, the teaching time without any patients present is closer to only 1 hour per week. See the attached letters from various residency programs in Utah.

We appreciate CMS' consideration of the above comments and look forward to an equitable resolution to the required compensation level of teaching physicians in non-hospital settings. If anyone has any questions regarding these comments, please call me at (801) 526-4553.

Sincerely,



David Squire
Executive Director

UNIVERSITY of VIRGINIA HEALTH SYSTEM

VICE PRESIDENT *and* CHIEF EXECUTIVE OFFICER
of the MEDICAL CENTER

/5

March 19, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS–1529–P
Mail Stop C4–26–5
7500 Security Boulevard
Baltimore, Maryland
21244-1850

Re: Comments on Proposed LTCH Rule
Extension of "25 Percent" Provision
File Code: CMS–1529–P

To Whom It May Concern:

The University of Virginia Medical Center submits the following comments on CMS' February 1, 2007 proposed regulations regarding "Prospective Payment System for Long-Term Care Hospitals RY2008." The University of Virginia Medical Center opposes these proposed regulations, for the reasons set forth below.

I. SUMMARY OF COMMENTS

- As CMS itself has interpreted the statute, adjustments to LTCH rates are to "reflect variations in the necessary costs of treatment among LTCHs." CMS' proposed rule does not explain how LTCH costs are affected by the identity of the referring hospital, and there is no reason to think that a LTCH's costs for treating patients from a hospital referring greater than 25 percent or 50 percent of the LTCH's patients should be any less than for other patients.

- CMS has contracted with RTI to review the clinical characteristics of patients best treated in LTCHs and the resources necessary to treat those patients. Hard data on which patients should be treated in LTCHs and the costs for treating them is the sort of factual foundation that should underlie payment policy. In this instance, CMS is acting prior to having that hard data and is proceeding without making a rulemaking record that supports its policy choices.

- Even if one accepts CMS' premise that adjustments to a LTCH's payment are appropriate when an individual referring hospital accounts for more than a certain percentage of a LTCH's admissions, CMS has not adequately addressed all situations arising when there are "MSA dominant" hospitals.

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434-243-9308 • Fax: 434-243-9328

- If finalized, this proposal would be intended by CMS to affect LTCHs' decisions on accepting patients from certain hospitals. Yet, CMS bars any provider from discriminating against Medicare patients on this basis. Finalization of this rule would put LTCHs in the untenable position of either violating Medicare's rule against not accepting patients who meet a provider's clinical admission criteria, or accepting patients for whom CMS will penalize them with inadequate payments.

- The factual premise that CMS relies upon to justify the proposed rule—that short-term acute care hospitals are "gaming" the system by not furnishing a full "episode" of care to patients transferred to LTCHs—is belied by CMS' own data which show that the length of stay in short-term acute care hospitals for patients transferred to LTCHs, exceeds the arithmetic mean length of stay for the DRG 475, the sole DRG for which CMS cited data.

- To the extent that there is any "gaming" by short-term acute care hospitals, the solution is to deal with those referring hospitals and is not to reduce payment to the LTCHs receiving patients referred from acute care hospitals.

- The Medicare hospital inpatient prospective payment system already reduces payment to the transferring hospital in most cases when a patient is discharged to an excluded provider, such as an LTCH, prior to the average length of stay for the DRG for an individual patient. Thus, if the referring hospital has lower costs (whether for good reasons or because of "gaming"), it will receive a reduced payment under existing regulations. A second reduction in payment to the LTCH cannot be justified, especially since CMS does not contend that a LTCH has any lower costs for patients transferred to the LTCH prior to receiving a full episode of care in an acute care hospital. Indeed, for such patients, it is logical to conclude that the LTCH's costs would be greater.

- The inclusion in the Administration's budget for savings resulting from extension of the "25 percent rule" to all LTCHs must not affect an unbiased review by CMS of comments to its proposal and consideration of how to proceed with the final rule.

II. University of Virginia Medical Center

The University of Virginia Medical Center ("UVA") operates 574 beds in Charlottesville, Virginia. UVA is, of course, part of the University of Virginia which also operates a School of Medicine. UVA is the training site for approximately 738 residents. UVA has a Medicare case mix index of 2.02. This is far above the average national median case mix of 1.3132. 71 Fed. Reg. 47870 (Aug. 18, 2006). UVA operates a Level I Trauma Center and, compared to many other hospitals, including the only other hospital in its MSA, treats a disproportionate percentage of patients with major multiple trauma.

A joint venture including UVA has received a Certificate of Public Need from the Virginia Department of Health to construct a 40-bed LTCH. The new facility will be located in Albemarle County, Virginia, approximately two miles from UVA's 574 bed facility, and

will not be a hospital-within-a-hospital under CMS definition. UVA sought approval for the LTCH in order to meet the clearly established clinical need for LTCH services.

Based on the most recent data available to us, UVA was responsible for approximately 75.82% of the admissions within its MSA.[1] Hence, under the CMS proposal, UVA is an "MSA dominant hospital." Therefore the threshold for a LTCH located in the Charlottesville area receiving full LTCH PPS payments for patients admitted from a single non co-located hospital would be 50%.

III. ADJUSTING LTCH RATES BASED ON THE SITE OF PRIOR ACUTE CARE HOSPITAL STAYS IS NOT AN "APPROPRIATE" ADJUSTMENT WITHIN THE MEANING OF THE STATUTE.

CMS bases its authority to issue this proposed rule under section 307(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). *Id.* at 4778, which states in part:

> [t]he Secretary shall examine and may provide for *appropriate* adjustments to the long-term hospital payment system, *including* adjustments to DRG weights, area wage adjustments, geographic reclassification, outliers, updates, and a disproportionate share adjustment. . . .

Pub. L. No. 106-554, 114 Stat. 2763A-497 § 307(b)(1), (emphasis added). CMS itself has interpreted the meaning of the statutory reference to "appropriate" adjustments. In CMS' view, this statutory provision has given it authority only "to provide for adjustments to reflect variations in the necessary *costs of treatment* among LTCHs." 72 Fed. Reg. 4776, 4801 (Feb. 1, 2007) (emphasis added).

CMS' interpretation of the law is entirely consistent with the examples of adjustments that Congress set forth in the statute and which are instructive in defining "appropriate" adjustments. Each one of the statutory examples of adjustments—DRG weights, area wages, geographical location, outliers, updates, and disproportionate share—relates to factors affecting *the cost to the LTCH* in treating patients. Thus, a reading of the plain language of the statute is that "appropriate adjustments" are based solely on factors affecting the costs of care. In this instance, however, CMS proposes to adjust payments downward to LTCHs receiving more than a stated percentage of patients from a single hospital *without any finding that the costs of caring for those patients in a LTCH are less than the costs for caring for other patients.*

Rulemaking should be based on relevant facts and those relevant facts need to be in the rulemaking record. CMS has produced no data showing how the costs of care in LTCHs are affected by which hospital treated the patient prior to admission to the LTCH or are

[1] While the proposed regulation addresses "discharges" instead of "admissions," the two statistics are simply opposite sides of the same coin.

affected by the percentage of admissions to the LTCH of patients discharged from a single short-term acute care hospital. CMS speculates that short-term hospitals may be "gaming" the payment system by discharging patients prematurely to LTCHs. Again, the rulemaking record is devoid of data supporting this proposition, but if it is accepted, the effect would be to *increase* the costs of care for the receiving LTCH since the LTCH would be receiving patients who had progressed less far in the entire course of their needed hospital care. See discussion below in Section VIII. CMS cannot properly penalize a LTCH for problems in overpayment to another hospital for services furnished prior to patients crossing the LTCH's threshold.

Since the proposed adjustment to LTCH payment rates is not based on the costs that LTCHs will incur in treating patients, the proposed adjustment is not permitted by the statute. Accordingly, CMS should simply withdraw this proposal.

IV. THE PROPOSED RULE SHOULD FOCUS ON MEDICAL NECESSITY AND CLINICAL PATHWAYS.

The focus of regulations clarifying the statute above instead should be on medical necessity and clinical pathways—that is, the need for the admission of types of patients into an LTCH, regardless of the patient's origin. If the patient needs LTCH services and there is a LTCH bed available, the LTCH should not be penalized for an appropriate admission.

Focusing on patients' clinical needs and the resources needed to meet those clinical needs is the only logical way to construct payment rates. CMS has already embarked on this course with its contract with RTI. CMS must believe that there is a need for the information and analysis it has contracted with RTI to provide in order for CMS to make informed policy decisions, or it would not have entered into an expensive contract to obtain that information. Yet, CMS has proceeded with this proposed rule without having obtained the information it has identified as relevant for informed decision-making. CMS should renew its focus on clinical factors which drive resource usage, and withdraw this proposal that focuses solely upon the short-term acute care hospital where the patient received treatment prior to his or her LTCH stay.

V. THE PROPOSAL'S ACCOMMODATION FOR "MSA DOMINANT" HOSPITALS DOES NOT ADDRESS THE PROBLEMS THAT WILL BE ENCOUNTERED BY INDIVIDUAL HOSPITALS, SUCH AS UVA, THAT ACCOUNT FOR WELL OVER 50 PERCENT OF THE DISCHARGES IN THEIR COMMUNITIES.

UVA is located in the city of Charlottesville, Virginia. Charlottesville is contiguous to Albemarle County, which comprises 726 square miles of Virginia. *See* http://www.albemarle.org/upload/images/forms_center/departments/community_development/forms/Albemarle_Information_Sheet_2006.pdf.

Charlottesville, Virginia has two general acute-care hospitals. In addition to UVA, a 574-bed facility, Martha Jefferson Hospital, operates a 176-bed hospital in Charlottesville.

UVA accounts for 75.82% of the admissions in the community. AHA Guide 2007. Both facilities are located in Virginia Health Planning Region 1 ("HPR1"). A Health Planning Region is defined as "a contiguous geographical area of the Commonwealth with a population base of at least 500,000 persons, which is characterized by the availability of multiple levels of medical care services, reasonable travel time for tertiary care, and congruence with planning districts." VA. CODE § 32.1-122.01. The latest data available from the Virginia Employment Commission indicates that HPR1 has a population of 1,019,533 people.

As of February 2006, the latest statistics available, there were 389 LTCHs in the country. Despite that fact, there are no LTCHs in HPR1. See CMS Website, http://www.cms.hhs.gov/LongTerm CareHospitalPPS/08_download.asp (Feb. 2006). There are only three LTCHs currently in operation in the entire Commonwealth, with an additional two planned to begin operation in 2008. Lake Taylor Hospital and The Hospital for Extended Recovery are both located in Norfolk, Virginia, and are over 160 miles from UVA. The LTACH at Riverside is located in Newport News which is also more than 160 miles from Charlottesville. Kindred Hospital-Richmond is scheduled to begin operations in 2007, and the Central Virginia Hospital for Restorative & Rehabilitative Care located in Lynchburg, Virginia is due to begin operations in 2008. Richmond is approximately 72 miles from Charlottesville. Lynchburg is approximately 64 miles from Charlottesville via extremely hilly terrain paved by non-interstate highway. A patient transfer from UVA to a LTCH outside of Charlottesville/Albemarle County would involve a one to three-hour ambulance journey.

CMS states that approximately 80% of all LTCH admissions are from acute care hospitals. *Id.* at 4812. CMS did not state the source for this data or precisely how it was computed. It is unlikely that only 80 percent of LTCH admissions come from acute care hospitals. With an average length of stay of 25 days, LTCHs are treating sick patients. It is very doubtful that these patients first presented to an LTCH. LTCHs do not generally have emergency rooms and it is rare for a patient to be admitted directly to an LTCH. It is likely that virtually all LTCH patients had an acute care hospital stay in the same "spell of illness." That is the statistic CMS should research and publish. Even when a spell of illness has been broken by a patient not receiving services on consecutive days, it is likely that there was an acute care hospital stay sometime not long prior to the LTCH stay.

In short, in a city such as Charlottesville which has two hospitals and which is relatively isolated from other cities, it is probable that a LTCH located in adjacent Albemarle County will receive the vast majority of its admissions, well over 80 percent, from the two hospitals in Charlottesville.

As an MSA-dominant facility accounting for over 75% of the admissions in its area, CMS has acknowledged that an LTACH in Charlottesville would have "unique needs." Yet, those needs are not sufficiently addressed by this proposed rule. 72 Fed. Reg. 4776, 4815

(Feb. 1, 2007). UVA's expects 80 percent of its LTCH patients to have had a previous stay in the same spell of illness at UVA because:

- UVA accounts for more than 75 percent of the hospital discharges in Charlottesville;
- UVA has a Level I trauma center and trauma patients are more likely to need LTCH services;
- UVA has a very high case mix of 2.02 and sicker patients are more likely to need LTCH services; and
- Charlottesville has only one other hospital in addition to UVA, and Charlottesville is relatively isolated from other areas and hospitals that might generate LTCH referrals.

On the basis of this demographic data, the Albemarle County LTCH's expectation of receiving approximately 80 percent of its referrals from UVA is completely reasonable and it is impossible to ascribe to that expectation any element of improper conduct or gaming by either the LTCH or UVA. In the face of these facts, CMS' 50 percent limitation is unrealistic and unfair. One of the reasons that it is unrealistic and unfair is that the 50 percent limitation applicable to a LTCH located in an MSA with a dominant hospital is based on neither a study of actual demographic data, nor an analysis of the clinical needs best served by LTCHs.

VI. CMS' Proposal Runs at Cross Purposes with the Medicare Rule that Hospitals Cannot Discriminate Against Medicare Patients.

CMS' proposal will put LTCHs in an untenable position. On the one hand, a Medicare provider may not discriminate against Medicare patients who meet the provider's admission criteria. As stated in CMS' own manual:

> A provider may have restrictions on the types of services it makes available and/or the types of health conditions it accepts, or may establish other criteria relating to the admission of persons for care and treatment. However, the law does not contemplate that such restrictions or criteria will apply only to Medicare beneficiaries as a class. It does contemplate, however, that if such restrictions or criteria apply to Medicare beneficiaries, they will be applied in the same manner in which they are applied to all other persons seeking care and treatment by the provider. Thus, a provider admission or patient policy or practice which is not consistent with the objective contemplated in the law may be used by CMS as a basis for termination of the agreement for cause.

Medicare Gen'l Info, Eligibility, & Entitlement Man. (CMS Pub. No. 100-01), Chpt. 5, § 10.2. In short, CMS prohibits a LTCH from turning away a referred Medicare patient on the basis that admitting the patient would cause the LTCH to exceed the applicable percentage limitation and cause the LTCH to be paid far less than its costs for that patient. On the other hand, CMS' policy rationale for creating a limitation on the percentage of patients that a LTCH can accept from a single hospital is clearly intended to affect the conduct of LTCHs in accepting patients. Thus, CMS is creating a policy incentive that is impossible for a LTCH to respond to without violating another CMS rule.

If CMS were to change its rule on discriminating against Medicare patients so as to permit LTCHs to deny admission to Medicare patients when such admissions would result in financial penalties to the LTCH, the result would be that patients would unnecessarily have to be transported considerable distances to other providers. Creating disincentives for patients to be treated at the LTCH closest to the discharging hospital is hardly in the patients' best interests since patients would be housed for a long stay at a site distant from their homes and families. This would also result in increased ambulance charges to the program.

VII. CMS' STATED REASONS FOR THE PROPOSED RULE ARE NOT SUPPORTED BY ITS OWN DATA.

CMS cites "gaming" by short-term acute care hospitals of the hospital inpatient prospective payment system as the reason for this proposed rule which extends the "25% rule" to all facilities. 72 Fed. Reg. 4776, 4812 (Feb. 1, 2007). CMS states that it is concerned that referring short-term acute care hospitals are discharging patients to LTCHs prior to the delivery of a full episode of care at the short-term hospital, leading to two payments for the patient. *Id.*

First, there should be no legitimate objection that Medicare makes two payments for LTCH patients, one to a short-term acute care hospital and another to the LTCH. As CMS states in the preamble, 80 percent[2] of the admissions to LTCHs are direct referrals from a short-term acute care hospital. CMS does not object categorically to two payments for such patients, and there is nothing inherently wrong with two payments for such patients. There would also be two payments for such patients if they were transferred to a SNF or rehabilitation hospital or unit. Thus, the issue is not the fact alone that there are two payments for such patients.

If CMS is paying twice for the *same* service, it has a basis to complain. As CMS' contractor, RTI, has pointed out in its report, "[u]nderstanding whether acute hospitals are already paid for these services or whether LTAC hospitals are providing specialized services not available in the acute hospital is *poorly understood.*" Research Triangle Report, 55-56 (Jan. 2007) (emphasis added). Therefore, there is no factual basis for a claim by CMS that there is any double payment for the same services.

[2] As noted above, we are virtually certain that this 80 percent statistic understates the percentage of LTCH patients who had a stay in a short-term acute care hospital as part of the same spell of illness.

CMS can also legitimately object to the *amount* of its payments *to* short-term acute care hospitals (or any other type of provider) for patients transferred to LTCHs, *if*, as it states in the preamble, less than the proper level of care is furnished at the referring provider, although why this should affect payment to the nonoffending LTCH is unexplained. Concern with the possibility of "gaming" by a referring short-term hospital was addressed more than twenty years ago when Congress and CMS created Quality Improvement Organizations ("QIOs")[3] that are charged with monitoring whether hospitals discharge patients prematurely or in an otherwise inappropriate manner. Such monitoring remains part of QIO's current activities.

Notwithstanding the existing safeguards against premature discharges, CMS contends that short-term acute care hospitals are prematurely discharging patients to LTCHs, and that such premature discharges occur regardless of whether the LTCH is a "hospital within a hospital." CMS' contention that short-term acute care hospitals are not furnishing the services for a full "episode" of care for patients discharged to LTCHs is meaningless because CMS never defines what services should be furnished in a short-term acute care hospital in a normal episode of care. By excluding from the "25 percent rule," any cases for which outlier payments were made to the referring short-term acute care hospital, CMS implies that the short-term acute care hospital has short-changed the patient and the Medicare program unless the case has fallen into outlier status. This is the wrong standard to apply. A case does not become an outlier until the DRG payment is *at least $24,485 less than the hospital's costs*, and even then the outlier payment is for only 80 percent of the hospital's actual costs in excess of the already absorbed loss of $24,485. 71 Fed. Reg. 59885, 59890 (Oct. 11, 2006), 42 C.F.R. § 412.84. CMS' target for outlier payments is 5.1 percent of PPS payments for the year, and since outlier cases are, by definition, high cost cases, fewer than 5.1 percent of cases nationally will qualify for outlier payments. Thus, it is grossly inappropriate for CMS to use outlier status as a statistical standard for whether a hospital has furnished the full "episode" of care in a case.

A more rational statistical standard for determining what, on average, is a typical episode of care is the average length of stay or average charges by DRG. While CMS has cited length of stay data for patients discharged to LTCHs from short-term acute care hospitals for a single DRG, *it has failed to compare that length of stay to the average.* The *sole* data that CMS has published to support its contention that short-term acute care hospitals are not furnishing a full episode of care to patients discharged to LTCHs compares the average length of stay for patients discharged to LTCHs that are hospitals within hospitals and to LTCHs that are not hospitals within hospitals. CMS' data show that the average length of stay for a single DRG in a short-term acute care hospital for Medicare patients discharged to LTCHs that are not hospitals within hospitals is 12.9 days, close to the average length of stay of 12.7 days in short-term acute care hospitals for patients discharged to LTCHs that are hospitals within hospitals. These two length of stay statistics for short-term acute care hospitals are not relevant to the costs of care in a LTCH, the only relevant

[3] These organizations were originally referred to as Peer Review Organizations ("PROs").

data for setting LTCH rates. Moreover, the data cited by CMS do not demonstrate any failure of short-term acute care hospitals to furnish full "episodes" of care.

First, the length of stay data for a single DRG is not convincing since there are many DRGs treated in LTCHs. CMS has the ability to analyze those DRGs assigned to patients who make up the top 80 percent of the discharges from LTCHs.[4] CMS could also analyze the DRG data for those cases for which its contractor advises LTCH care is most appropriate. CMS has taken neither course; instead it has relied upon length of stay data for a single DRG.

Even if the data for one DRG is viewed as representative, the data comparison presented by CMS is meaningless. CMS compares the 12.7 day length of stay for one DRG for patients transferred to a co-located LTCH and the 12.9 day length of stay for that same DRG for patients transferred to a LTCH that is not co-located. On the basis of this comparison, CMS concludes that gaming is occurring both when patients are referred to a co-located LTCH and when they are referred to any other LTCH. CMS' conclusion stands only if CMS can show that there is gaming by acute care hospitals which are co-located with a LTCH. Indeed, the same data could be used to support the opposite conclusion. If the assumption is that there is no gaming by hospitals that are not co-located with LTCHs, the data then show that the hospitals co-located with LTCHs are *not* engaged in gaming the system. In fact, CMS' own data show that the length of stay for patients in DRG 475 transferred to LTCHs considerably *exceeds* the average length of stay for that DRG. Thus, CMS' data show that there is no evidence of a pattern of premature discharges for patients referred from short-term acute care hospitals to LTCHs.

CMS' data for 2004[5] reported in the FFY2007 hospital inpatient PPS rule indicates an arithmetic mean length of stay of 11.0464 days for DRG 475. 70 Fed. Reg. at 47663. So, acute-care hospitals which transfer patients to LTCHs keep the patients *longer* within their four walls than hospitals which discharge the patient to a non-LTCH destination (comparing 11.05 days to either 12.7 or 12.9 days). Therefore, CMS' data contradict its *a priori* assumption that short-term acute care hospitals are prematurely discharging patients entering LTCHs. Actually CMS data indicate the opposite, i.e., that short-term acute care hospitals are keeping patients ultimately discharged to LTCHs *longer* than the average length of stay. Also omitted from the preamble to the proposed rule is the difference between the overall Medicare average length of stay of 5.5 days and the lengths of stay for patients discharged to LTCHs. *See* DATA BOOK: HEALTHCARE SPENDING AND THE MEDICARE PROGRAM 81, Medicare Payment Advisory Commission (June 2006).

VIII. THE PROPOSAL PENALIZES LTCHS FOR THE PERCEIVED MISDEEDS OF REFERRING HOSPITALS.

[4] In the annual inpatient hospital PPS rule, CMS recomputes how approximately *11 million* cases would be grouped and paid under proposed changes to the DRG grouper and payment rates. In comparison, the task of analyzing data on cases where patients received services from both short-term hospitals and LTCHs would have been miniscule.

[5] We cite 2004 MedPAR data since CMS cites 2004 MedPAR data in the proposed LTCH rule.

Even if "gaming" of the system were to occur, an assumption for which CMS has presented no evidence, it benefits the transferring acute-care hospital, not the LTCH. As noted above, the effect of any gaming by the short-term acute care hospital would be to *increase* the costs of the LTCH and that makes it especially irrational to penalize the LTCH.

The issue of whether payment adjustments are appropriate when a hospital discharges a patient to another provider is not new, and CMS' current rules apply a reduction in payment to the short-term acute care hospital when there is discharge to an excluded hospital, which includes a LTCH. 42 C.F.R. § 412.4(c)(1). These reductions will apply to the majority of the discharges from short-term acute care hospitals to LTCHs, but CMS fails to so much as mention this other existing rule in proposing to add an *additional* payment reduction for patients transferred to a LTCH. For the 50 most frequently reported DRGs for LTCH patients, as reported by CMS' contractor RTI, 35 are subject to reductions in payment at the transferring short-term acute care hospital if the transfer occurs prior to the transferring hospital's keeping the patient up to at least the average length of stay.[6]

In summation, CMS has not demonstrated that where a patient is referred from in any way decreases the costs of care in a LTCH, and logic suggests that an early discharge from a short-term acute care hospital would increase the costs for care at the LTCH. CMS also has not demonstrated that the aggregate payments made to short-term acute care hospitals and LTCHs are excessive. In addition, CMS fails to acknowledge that under current regulations, it reduces payments to the transferring short-term acute care hospital when it discharges a patient to any excluded provider if the length of stay is below the average for the patient's DRG. Thus, the issue identified by CMS has already been addressed in other CMS regulations. Finally, although not relevant to amounts that should be paid to LTCHs, CMS has not shown that the payments to short-term acute care hospitals are excessive for services furnished to patients discharged to LTCHs.

IX. The Importance of the Notice and Comment Process for This Rule

The savings to be effected by this proposed rule are already "scored" and claimed as savings in the budget the Administration has submitted to Congress. These claimed savings from a rule that has not been finalized could be cited in subsequent attacks on the final rule as evidence that the comment process was not legitimate. Accordingly, we believe that it is especially important for CMS to consider and address reasonably all rulemaking comments.

X. Proposed Modifications to the Proposed Rule

For the reasons set forth above, UVA believes that the proposed rule should be withdrawn. Rather than focus on where LTCH patients are referred from, CMS should

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[6] We used RTI's DRG data in making this comparison. However, CMS' FY 2007 IPPS Final Rule discontinued use of DRG 475. 71 Fed. Reg. 47870, 48198 (Aug. 18, 2006). Therefore we consulted the FY 2006 IPPS Final Rule to include DRG 475. 70 Fed. Reg. 47278, 47630 (Aug. 12, 2005).

instead focus on what services require the LTCH level of care, and how CMS should pay for those services so as to cover the reasonable and necessary costs that an LTCH will incur.

If CMS continues to believe that there is "gaming" by short-term acute care hospitals, it should support that finding with data showing that there are shorter than average lengths of stay for patients transferred to LTCHs for the DRGs that account for most LTCH admissions. In addition, CMS should show how its present reductions in payment for post-acute care transfers do not already sufficiently address any "gaming" that may exist.

To the extent that CMS continues to focus on the source of patients, it must modify its rule to accommodate situations such as Charlottesville/Albemarle County, Virginia where the "dominant" hospital will expectably and properly account for approximately 80 percent of the referrals to an Albemarle County LTCH.

Thank you for the opportunity to comment on CMS' proposed LTCH regulations. We believe that consideration of these comments and incorporation of the suggestions they contain will serve to better promote the goals of efficiency and effectiveness in the provision of long-term care for our patients.

Sincerely,

R. Edward Howell
Vice President and Chief Operating Officer

cc: Judy Richter (by e-mail: jrichter@cms.hhs.gov)

E. Darracott Vaughan, Jr., MD
Chair, Medical Center Operating Committee

Leonard W. Sandridge
Executive Vice President and Chief Operating Officer
University of Virginia

Arthur Garson, Jr., MD
Vice President and Dean
University of Virginia School of Medicine

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March 2, 2007

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: PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION (42 CFR 413.79)

Volunteer Faculty
CMS's proposed rule regarding non-hospital training sites unduly impacts family medicine residencies. Volunteer faculty are a substantial component of family medicine supervisors. As family medicine residents require training across numerous specialties, residencies rely heavily on volunteer faculty. The typical family medicine non-hospital rotation involves residents participating in the care of clinic patients, typically in an apprenticeship model. The faculty do not adjust their clinic schedules to accommodate for resident participation; they maintain a normal clinic schedule and see the same number of patients whether a resident is rotating with them or not. These faculty volunteer their time, typically because they feel a sense of responsibility to contribute to the educational model that educated themselves.

Presumptive Level of Time for Supervising Physician Evaluation and Didactic Activities
Residents receive their training from volunteer faculty through valuable hands-on patient care. Rarely do they receive any additional didactic training outside of patient care in the office. If this occurs at all, it is at most one hour per week, not the proposed 3 hours.

Proposed Proxy Physician Salary Data
Should CMS uphold its desire to calculate costs of resident training, it should use geographic salary data rather than national data. The state of Utah has lower wages than other regions; national salary data would misrepresent the actual cost of training in Utah as being higher than it really is.

Thank you for taking these points into consideration.

Sincerely,

Sonja Van Hala, MD, MPH
Program Director
University of Utah Family Medicine Residency

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Seton Specialty Hospital

70 Years and Growing

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Dedication
Affirming the hope and joy of our ministry

Creativity
Courageous innovation

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention CMS-1529-P, Mail Stop C4-26-5
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: <u>February 1, 2007 Proposed Rule - Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification</u>

Seton Specialty Hospital, Inc. ("SSH") is writing to express its concern over proposed changes and comments contained in the February 1, 2007 proposed rule ("Proposed Rule") impacting long-term care hospitals ("LTCHs"). Specifically, SSH believes that the Centers for Medicare and Medicaid Services' (CMS') proposed extension of the 25% rule (codified at 42 C.F.R. 512.534) to freestanding LTCHs (i) violates its own stated goal to place Medicare patients in the most appropriate post-acute care setting; (ii) greatly restricts patient choice and interferes with the practice of medicine by arbitrarily paying LTCHS at the LTCH payment rate for no more than 25% of its patient referred from any one hospital. Moreover, we believe that CMS's proposal to pay for Short Stay Outlier ("SSO") patients in a manner similar to patients covered by IPPS is, at best, misguided and may have the unintended effect of creating a strong incentive for some LTCH providers to slow the provision of care in an effort to lengthen a patient's stay to avoid an SSO in hopes of obtaining the full diagnostic related group ("DRG") payment.

In short, SSH believes CMS should not extend the 25% rule to freestanding LTCHs and should not adopt its proposed SSO policy. SSH believes that CMS's anecdotal concerns surrounding patient-shifting is misplaced and can be more properly addressed by following MedPAC's June 2004 recommendations that CMS designate Quality Improvement Organizations (QIOs) to review the medical necessity of LTCH patient admissions and establish clinically appropriate admission criteria.

I. <u>Extension of 25% Rule to Freestanding LTCHs</u>.

CMS' appears to base its extension of the 25% Rule to freestanding LTCHs on the erroneous notion that an acute care hospital's discharge of a patient to an LTCH is "premature" if the patient has not reached cost outlier status at the acute care hospital. This notion is in no way justified. CMS' only support for its belief is, from SSH's vantage point, unsupported anecdotal evidence. SSH has yet to see CMS provide clinical or financial evidence that LTCH patients admitted from

general acute care hospitals are being discharged prematurely. It is, at best, unfortunate that CMS appears to have such a dim view of the health care landscape that it believes that the only reason a patient would be discharged to an LTCH from a general acute care hospital would be to reap supposed financial rewards. In fact, physicians utilize their expertise and experience to discharge patients to LTCHs because the specialized care they can receive at an LTCH is very different than services provided in a general acute care hospital, and such care, and the timing of such care, is clearly in the best interests of the patients medical care.

Plainly said, expanding the 25 percent rule is "bad policy." LTCHs serve very complex patients, including trauma, burn, and transplant patients. Many of these LTCH patients come from one of the few major hospitals in the area that are able initially to treat such patients. To extend the 25% Rule to freestanding LTCHs rather than addressing concerns regarding inappropriate discharges through the establishment of clinical criteria makes it difficult or impossible for a hospital to admit appropriate patients. Moreover, it results in different levels of Medicare payment for identical patients depending on whether they have the good fortune to get sick early in a fiscal year or the bad fortune to do so after the 25% limit has been reached. Again, if CMS continues to believe patients are being inappropriately transferred, it should pursue establishment of clinically appropriate admission criteria instead of imposing arbitrary, complex, expensive and oblique motivators. Similarly it should make use of the QIO's which already are in place and which were established by CMS for the very purpose of insuring appropriate use of hospital services.

II. Short Stay Outliers.

By way of background, SSH is a decade-old faith-based, not-for-profit LTCH system operating 98 beds in central Indiana. Our hospitals admit only very high acuity, long stay patients (e.g., our year-to-date LTCH case mix index ("CMI") is 1.6652). SSH believes that it is among the pioneers in development of an effective long-term, high acuity clinical model and we have demonstrated exceptional quality, outcomes and cost effectiveness.

CMS has, for some time, expressed concern about inappropriate admissions of low acuity patients into LTCHs. SSH has observed this very behavior at other LTCHs within the industry. It is our experience that many LTCH providers seek to admit chronically ill "slow-recovery" patients as a primary target population. These patients have little difficulty meeting the 25-day LTCH average length of stay criteria, and while these patients may meet continued stay criteria, we believe many could be cared for in a less acute setting.

In our experience the LTCH model works best when it is applied to a much smaller, more narrowly defined population of patients whose otherwise swift recovery has been impeded by multiple serious physiological complications. With excellent LTCH care some of these patients recover sufficiently to be transferred to

a lower level of care in 12 to 20 days, others, of course, take longer. These patients may become SSOs and they are among the real success stories of our industry. We would welcome and were looking forward to refined clinical admission criteria that would stabilize the industry around this patient group. We believe this is what was originally envisioned when the groundwork for LTCHs was laid in 1983 with the introduction of the inpatient prospective payment system.

Unfortunately, the approach taken in the Proposed Rule, most particularly the introduction of a fourth (inpatient prospective payment system ("IPPS") equivalent) SSO payment option, fails to accomplish this goal. Although it may, in fact, reduce some inappropriate admissions, it will actually encourage others while simultaneously drastically reducing payment for clinically appropriate LTCH patients. The proposed regulations also establish a harmful precedent for using payment mechanisms as a substitute for clinical judgment, encourage further case management abuse by some providers and significantly distort the intent of the prospective payment system

The basic premise behind the prospective payment system is to provide an average payment for short and long stay patients, thereby creating incentives for early discharge and efficient operation. The proposed payment mechanism totally inverts this perspective. Consequently, it will provide a VERY strong incentive for some providers to slow down the provision of care in order to LENGTHEN the patient's stay in hopes of avoiding an SSO in favor of the full DRG payment. Such behavior would be in clear opposition to CMS' intent and the public good, yet it would be very easy to do by an unscrupulous provider. The Proposed Rule re-introduces all of the backward incentives associated with the old "cost-based" reimbursement, but at a much higher level since it will encourage not just recovery of additional cost but will actually offer a profit for longer stays. Not coincidentally, this could effectively RAISE costs to the Medicare program.

Historically, LTCHs have had a mortality rate of approximately 20% and many of these deaths occur in such a manner as to make the patient a SSO. These patients do not die of "low acuity." Obviously, these are very sick people. But, in our hospitals at least, their deaths are not easily foreseen and had their complex clinical course not taken their lives, virtually all of them would have gone on to be full stay patients. This group of patients, in fact, accounts for more than 20% of our ministry's SSO population. The assumption that these patients could better be cared for in a less acute setting simply is not true. And, of course, it is well known that patients consume many expensive resources during an end of life illness. The "IPPS equivalent" payment rate was designed for a population that, by and large, is less acute, experiences fewer co-morbidities and which more typically survives.

Even for non-mortality patients, CMS' assumption that SSO patients, by definition, would be more appropriately placed in a less costly provider setting is erroneous. In our hospitals the CMI of SSO patients is virtually identical to that of our full stay and cost outlier populations. The average length of stay of our SSO

patients is over 15.96 days, almost 3 times the average length of stay in a typical acute care hospital and just 10 days less than the only definition CMS has ever provided for LTCH patients.

It appears that our average "IPPS equivalent" SSO payment is only sufficient to cover the cost of providing 3-4 days of care. The proposed payment mechanism simply fails to provide for any possibility of an appropriate LTCH patient whose stay falls between these extremes. As proposed, the payment incentives further define our industry solely by length of stay. The proposed regulations only serve to reinforce incentives to admit "slow recovery" patients (many of whom might be well cared for in SNF's or with home care) instead of appropriately high acuity complex patients.

It is our belief that the LTCH industry will not be stabilized and allowed to develop its full clinical and economic value until appropriate clinical admission criteria are developed that SPECIFICALLY and EFFECTIVELY limit entry to very high acuity, complex patients. Until this occurs, too many providers will continue to find ways to admit low acuity patients and capture a payment mechanism that was carefully developed to serve complex, high acuity patients. This will continue to offer the high profit margins that drive the rapid growth of LTCHs.

Given the above comments, SSH urges CMS not to extend the 25% rule to freestanding LTCHs and to not adopt its proposed SSO policy.

Thank you for the opportunity to comment on the Proposed Rule.

Sincerely,

Peter H. Alexander, Administrator
Seton Specialty Hospital, Inc.

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BRETT LOPER,
MINORITY STAFF DIRECTOR

March 20, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
Hubert Humphrey Building, Room 314-G
200 Independence Avenue, SW
Washington, DC 20201

Dear Ms. Norwalk:

I am concerned about a provision in the Center for Medicare and Medicaid Services' (CMS) proposed Rate Year 2008 Long-Term Care Hospital (LTCH) rule regarding the expansion of the "25 percent rule" to freestanding LTCHs. While I recognize CMS' desire to restrain spending growth on LTCH services, the current 25 percent rule is misguided and should not be expanded further.

I am disappointed that CMS did not incorporate the recommendations made by the Research Triangle Institute (RTI) in their CMS-commissioned report. Congress patiently awaited the results of this study, which was publicly released nearly two years after its due date, with the hopes that CMS would incorporate RTI's findings and recommendations in any LTCH payment reform initiative. However, CMS once again chose to ignore calls for the development of LTCH patient admission and facility criteria. Instead, CMS opted to favor arbitrary patient quotas that will likely restrict access to needed care.

Support for LTCH patient admission and facility criteria is not a new concept. In their June 2004, report, MedPAC unanimously recommended that LTCHs be defined on the basis of facility criteria while only admitting patients that require LTCH-level care. MedPAC stated that, "to ensure that patients treated in LTCHs are indeed those for whom this care is the most appropriate and that Medicare is a prudent purchaser, [we] support the adoption of criteria that would delineate the types of patients who are appropriately treated in this setting and more distinctly define these facilities." Shortly thereafter, I signed a letter to Administrator McClellan urging CMS to scrap the 25 percent rule in favor of medically-based patient admission criteria.

If a Medicare beneficiary requires the intensive level of care that LTCHs provide, it should not matter from which acute care hospital this beneficiary was transferred. CMS should be investing its time and resources on the development of long-overdue patient admission and facility criteria instead of expanding a flawed rule that puts CMS' bottom-line ahead of the health care needs of seniors.

With kind regards, I am,

Sincerely yours,

JIM McCRERY
Ranking Member
Committee on Ways and Means

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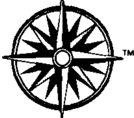
LANDMARK



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Center of Excellence for the Medically Complex Patient

March 20, 2007

The Honorable Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1529-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: ***Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 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:

As a physician involved with Landmark Hospital in Cape Girardeau, Missouri, I have serious concerns about the proposed "long term acute care" (LTAC) hospitals regulation the Centers for Medicare and Medicaid Services (CMS) published on January 25th, 2007, that introduces significant changes to the way LTAC hospitals are reimbursed by Medicare. While I understand CMS has concerns about the number of LTAC hospitals, an arbitrary admission quota is not a good answer. The use of clinical admission criteria, as included in legislation introduced in both the U.S. Senate and House of Representatives, is a much more appropriate way to ensure only appropriate patients are treated in LTAC hospitals. CMS' proposal is full of inequity, especially for hospitals such as our which has only two referring general hospitals. Local LTACH care should not be restricted to only a few very large cities. This proposal would force us to send our patients over two hours away and thereby deny them treatment options locally. It is precisely this local treatment option that has been responsible for our above industry outcomes.

Relevant changes are outlined below with comments:

1. Late last year, CMS received a report from RTI that it commissioned regarding LTAC hospital certification criteria. The RTI study was generally positive for the LTAC hospital industry, conclusively acknowledging that LTAC hospitals play a legitimate and constructive role in the continuum of American healthcare services. This proposed CMS quota rule pays little heed to the RTI study which CMS commissioned and funded. The proposed quota rule will cause many LTAC hospitals to close, especially in underserved and rural areas which have only one or two general hospitals. This especially pertains to our hospital.

2. In the face of several years of regulatory delays, a number of Members of Congress sponsored legislation to address the criteria issue for LTAC hospitals. In the U.S. Senate, Sen. Kent Conrad and Sen. Orrin Hatch introduced S. 338. In the U.S. House, Rep. Earl Pomeroy (D-ND) and Rep. Phil English (R-PA) sponsored a similar bill, H.R. 562. These bills would establish criteria to define what an LTAC hospital is and which patients should be treated there. They would limit the type of patients who can be treated in an LTAC hospital and reduce Medicare spending on LTAC hospitals by $1-2 billion over five years. These bills present a rational way to limit spending on LTAC hospitals, as opposed to the 25% rule that will create unnecessary and uneven hardships for patients and hospitals.

3. A few more examples of harm the 25% rule proposal would cause include:
   - Loss of local LTACH services in all but large metropolitan areas
   - Fragile patients would have long ambulance rides to access LTACH care
   - Families of patients would have long drives to see loved ones in LTAC Hospitals, for over 25 days average hospitalization
   - Patients would have to drive past LTAC hospitals with empty beds in their community and drive to another city to get LTAC care, because of the quotas
   - The 25% quota does not work in Cities with only 1 or 2 acute care hospitals. There is no place for the first 25% of patients to come from, before the matching 25% from the local hospital can be admitted.
   - Constant CMS changes lead to healthcare industry instability
   - The constant annual changing of regulations and reimbursement hurts small businesses that are trying to build long term companies that provide quality healthcare services to very ill patients. Companies cannot plan for the future when CMS significantly changes the regulations every year.
   - Capital commitments have been made by companies to build new hospitals; the 25% rule could cause bankruptcies caused by the inability to service lease payments and guaranties that were required to get the new hospitals built.

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. These policies discriminate against patients in the 26th percentile and higher and patient care will suffer.

The affect of the existing 25% rule and other changes made over the last three years have not been fully documented yet and CMS does not yet have data to confirm that the policy is achieving the stated policy goals and not having adverse effects on patient care. The proposed 25% rule expansion is a draconian quota system that would cause the most harm to patients and LTACHs in rural and underserved areas. This proposal should be dropped, if not for all free-standing LTACHs, at least for areas that have less than 4 equivalent STAC hospitals.

Please consider and decide the following:

1. Not implement a 25% admission limit, if not for all free-standing LTACHS, at least for rural, underserved, and other areas with less than four equivalent sized general hospitals; or
2. If the 25% rule for free-standing hospitals is implemented, permanently grandfather existing LTACHs and hospitals currently being constructed to become LTACHs.

This would provide sensible governing:

- Companies that have invested in and guaranteed long term hospital leases, based on the rules in existence, would have a chance to survive and meet their obligations.
- Appropriate LTACH patients could receive care in their home town, or closer to home, if an LTAC Hospital is already there.
- Patients could be treated by their own doctor, instead of getting a new doctor in the town they have to travel to.
- Families could visit their loved one daily without an extra burden of travel, lodging, meals and other expense and burden.

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

1. ***Overall Payment Adequacy***. The Medicare Payment Advisory Commission (MedPAC) found that LTAC hospital margins are between 0.1% and 1.9% (MedPAC Report to Congress, March 2007). Yet, CMS projects the proposed rule would reduce payments by 2.9%, which results in rates below the cost of care. In addition, CMS's estimate understates the actual impact by approximately 0.9% because it fails to account for the negative impact of raising the high cost outlier threshold by $3,887 per case. CMS should not propose LTAC hospital rates that fall below the cost of care. The proposed rates are not reasonable nor adequate given Medicare's goal of covering providers' cost of care. Furthermore, payments would be reduced by a much greater percentage for LTACHs serving rural and underserved areas that have less than at least three or four general hospitals.

2. ***Short Stay Outlier Payment Adjustment***. CMS also proposes to pay LTAC hospitals a reduced rate for "very short stay" outlier cases. CMS again justifies this proposal based on the concern that Medicare should not pay twice for a single episode of care. Less than one year ago, CMS finalized a rule that pays LTAC hospitals no greater than cost for all short stay outlier cases. It is too soon to implement further payment adjustments when the new policy has been in effect for less than one year and the impact has not been assessed. LTAC hospitals have no incentives to admit patients that will be "short stay" when LTAC hospitals are already paid no greater than cost for these patients.

LANDMARK HOSPITAL of Cape Girardeau
3255 Independence Street • P.O. Box 1590 • Cape Girardeau, MO 63702-1590
www.landmarkhospitals.com

3. ***Market Basket Update.*** CMS proposes paying LTAC hospitals a 0.71% market basket update, less than the full market basket update of 3.2%, which represents an estimate of actual cost increases experienced by LTAC hospitals. CMS should provide the full market basket increase, especially in light of other payment adjustments, or the cumulative effect of the proposals results in LTAC hospital rates below the cost of care. Nurse and other staff, supplies, and drug costs continue to increase faster than inflation.

4. ***LTAC Hospital Certification Criteria.*** Legislation has been introduced in the Senate (S. 338) and House (HR 562) to revise LTAC hospital certification criteria to implement MedPAC recommendations of over two years ago. Congress has made it clear that revised LTAC hospital certification criteria, not continued payment cuts, is the preferred policy route to address issues of concern. The proposed rule continues a pattern of arbitrary and punitive payment cuts, based upon questionable assumptions and incomplete or outdated data, which will hurt LTACHs and Medicare beneficiaries. An approach that would better serve Medicare beneficiaries would be to work together with the LTACH industry and the Congress to develop new certification criteria to better define LTACH facilities and patients to accomplish this goal and help stabilize Medicare reimbursement to LTACHs.

5. ***LTAC Hospital Growth.*** CMS continues to raise concerns about growth in the number of LTAC hospitals. However, the cumulative effect of CMS's recent changes and existing payment policies have halted, and possibly reversed, the growth of new LTACHs, and LTACH margins are estimated by MedPAC to be at or near zero. Growth in the number of new LTACHs has stopped.

6. ***CMS is interfering with patient choice and the practice of medicine.*** The proposed rule greatly restricts patient choice and interferes with the practice of medicine by arbitrarily paying LTACHs at the LTACH payment rate for no more than 25% of its patients referred from any one hospital. This policy also violates the agency's own stated goal to place Medicare patients in the most appropriate post-acute care setting. CMS should implement an LTACH PPS that recognizes the medically complex care LTACHs provide and the will of Congress to fairly pay for LTACH services. The Congress, the LTACH industry, MedPAC, and RTI International (which recently provided a report to CMS on LTACHs) all agree that LTACHs serve an important role in caring for medically complex patients who need long-term hospital stays. The combined effect of this proposed rule makes clear that CMS does not agree with this most basic premise. These proposed policies will continue to erode the LTACH PPS by reimbursing LTACHs for fewer and fewer medically complex patients at the LTACH PPS rates.

7. CMS must implement an LTACH PPS that fairly reimburses LTACHs for the costs they incur in caring for Medicare beneficiaries, in keeping with the statutory mandate of Congress. The proposed changes to the regulations will bring LTACH reimbursement below their cost of care.

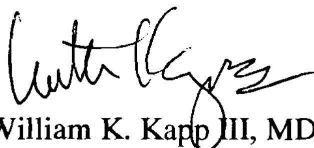
Conclusion

The 25% admission from any one hospital policy will have a disparate impact on LTACHs in areas without at least four equivalent referral hospitals – primarily underserved, rural and other nonurban markets – that is not appropriately accounted for with the limited number of exceptions to the 25% rule. CMS should not extend the current 25% rule, or any similar policy, to freestanding LTACHs or grandfathered LTACHs. However, if CMS finalizes this policy, it should:

(1) Grandfather all existing and under-development freestanding LTAC hospitals from the rule altogether, and
(2) Set the applicable percentage for all new freestanding LTACHs at 50% in light of the lesser policy concerns CMS has with these hospitals as compared to co-located LTACHs, and
(3) Exclude rural areas and other cities with less than 4 equivalent hospitals from the 25% rule.

Thank you for your attention to the important considerations related to LTAC hospitals raised in this letter.

Sincerely,



William K. Kapp III, MD
President

LANDMARK HOSPITAL of Cape Girardeau
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www.landmarkhospitals.com

February 26, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Attention: 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: Policy Changes.

Dear Ms. Norwalk:

Firelands Regional Medical Center (Firelands) is a 419 registered bed general non-profit hospital comprised of three campuses located in Sandusky, Ohio. Firelands is now the sole provider of acute care inpatient hospital services in Erie County. Firelands is the result of the 1985 merger of Good Samaritan Hospital and Sandusky Memorial Hospital to form Firelands Community Hospital followed by the August 2001 acquisition of Providence Hospital to form Firelands Regional Medical Center. Community leaders and hospital officials determined that by consolidating hospital resources the healthcare needs of Erie County would be most effectively and efficiently met.

The intent and goal of Firelands is to provide north-central Ohio the complete continuum of healthcare, at the highest quality. Over two years ago Firelands identified the community need of a local Long-Term Care Hospital (LTCH) and since that date we have worked to fill that need. The results of a survey of the medical staff, at Firelands, clearly indicated the need for a LTCH in the Sandusky area. This rule would not allow Firelands to meet the community needs and thus would disallow the residents of Erie County the possibility of receiving the complete continuum of healthcare in a local setting.

A satellite LTCH located in Sandusky, Ohio will (i) increase availability and coordination of long-term acute care services in the Sandusky area, (ii) increase efficiencies and economies in the delivery of long-term acute care services, and (iii) improve the quality of care of persons with chronic or medically complex conditions provided to patients in the Sandusky area who today must travel over 25 miles to receive this level of care while leaving behind the very medical team that will likely coordinate their continued recovery once discharged from the LTCH. The proposed Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals, regulations (CMS-1529-P) and the expansion of special payment provisions for long-term care hospitals (LTCH) hospitals within hospitals and LTCH satellites will eliminate the availability of long-term acute care services in the Sandusky area.

The proposed regulatory changes will threaten access to care for patients in the Sandusky area with unresolved acute or chronic conditions, catastrophic injuries, and/or multi-system disease processes requiring highly skilled care and an extended recuperation period. We find that the proposed regulatory change fails to recognize the importance of LTCHs in areas that have sole community acute care providers and sole county acute care providers. Firelands feels the proposed changes will unfairly penalize patients that live in these communities.

Firelands is asking that CMS not change the rules for reimbursement for LTCHs. These rule changes will eliminate all LTCHs in communities with a sole acute care provider, such as Erie County. Erie County has a need for a local LTCH and Firelands would like to provide our community with that level of care, but the proposed rule changes make LTCHs not viable, and thus make it impossible for us to meet the community's healthcare needs.

Please do not hesitate to contact me if I can answer any questions regarding Firelands's efforts to meet our community's need of having a LTCH.

Sincerely,

Charles A. Stark
President and CEO

21-1

March 16, 2007

BY OVERNIGHT MAIL

The Honorable Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1529-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: ***Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 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:

I have serious concerns about the proposed "long term acute care" (LTAC) hospitals regulation the Centers for Medicare and Medicaid Services (CMS) published on January 25th, 2007, that introduces significant changes to the way LTAC hospitals are reimbursed by Medicare. While I understand CMS has concerns about the number of LTAC hospitals, an arbitrary admission quota is not a good answer. The use of clinical admission criteria, as included in legislation introduced in both the U.S. Senate and House of Representatives, is a much more appropriate way to ensure only appropriate patients are treated in LTAC hospitals. CMS' proposal is full of inequity, especially for smaller cities that have only a few general hospitals. Local LTACH care should not be restricted to only a few very large cities.

Comments on the proposed rule are summarized in the following paragraphs:

A. "OTHER PROPOSED POLICY CHANGES FOR THE 2008 LTCH PPS RATE YEAR"
Proposed Extension of 25% Patient Quota Rule to Freestanding LTAC hospitals. CMS proposes a payment penalty for freestanding LTAC hospitals for every patient over a 25% threshold that comes from any single acute care hospital referral source. In addition, CMS proposes to revoke "grandfather" status from certain "Hospital within Hospital" LTAC hospitals that have been exempt from this rule. The proposed regulation would limit the way patients are referred to LTAC hospitals, an LTAC hospital could not have more than 25% of its patients referred from any one general hospital. I would like to comment on some of the harmful impact to patients and LTAC hospitals the regulation would cause, as well as better options to achieve the same goals:

1. With respect to the proposed rule, the Medicare Payment Advisory Commission (MedPAC) has noted that these referral quotas are a rather crude and unsophisticated approach to dealing with hospital admissions. No other Medicare-reimbursed facility has to deal with such draconian policies. These admission quota limits – which even MedPAC says are arbitrary -- ignore the clinical and quality of care considerations that should be the primary determinant of access to LTAC hospital care.

2. It has been almost three years since MedPAC called for CMS to create certification criteria to address the growth of the number of LTAC hospitals. Instead of imposing a crude and unfair quota rationing system, CMS should develop certification criteria for America's LTAC hospitals.

3. Late last year, CMS received a report from RTI that it commissioned regarding LTAC hospital certification criteria. The RTI study was generally positive for the LTAC hospital industry, conclusively acknowledging that LTAC hospitals play a legitimate and constructive role in the continuum of American healthcare services. This proposed CMS quota rule pays little heed to the RTI study which CMS commissioned and funded. The proposed quota rule will cause many LTAC hospitals to close, especially in underserved and rural areas which have only one or two general hospitals.

4. In the face of several years of regulatory delays, a number of Members of Congress sponsored legislation to address the criteria issue for LTAC hospitals. In the U.S. Senate, Sen. Kent Conrad and Sen. Orrin Hatch introduced S. 338. In the U.S. House, Rep. Earl Pomeroy (D-ND) and Rep. Phil English (R-PA) sponsored a similar bill, H.R. 562. These bills would establish criteria to define what an LTAC hospital is and which patients should be treated there. They would limit the type of patients who can be treated in an LTAC hospital and reduce Medicare spending on LTAC hospitals by $1-2 billion over five years. These bills present a rational way to limit spending on LTAC hospitals, as opposed to the 25% rule that will create unnecessary and uneven hardships for patients and hospitals.

5. A few more examples of harm the 25% rule proposal would cause include:
   - Loss of local LTACH services in all but large metropolitan areas
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   - Constant CMS changes lead to healthcare industry instability
   - The constant annual changing of regulations and reimbursement hurts small businesses that are trying to build long term companies that provide quality healthcare services to very ill patients. Companies cannot plan for the future when CMS significantly changes the regulations every year.
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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. These policies discriminate against patients in the 26th percentile and higher and patient care will suffer.

The affect of the existing 25% rule and other changes made over the last three years have not been fully documented yet and CMS does not yet have data to confirm that the policy is achieving the stated policy goals and not having adverse effects on patient care. The proposed 25% rule expansion is a draconian quota system that would cause the most harm to patients and LTACHs in rural and underserved areas. This proposal should be dropped, if not for all free-standing LTACHs, at least for areas that have less than 4 equivalent STAC hospitals.

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. In addition, the same rationale for creating grandfathered status for PPS-exempt hospitals that were established before the HIH regulations took effect holds true for freestanding LTACHs under the current proposal to extend the 25% rule to them. If CMS finalizes this policy in spite of strong congressional and industry opposition, all existing and under-development freestanding LTACHs should be grandfathered from compliance with the new rule.

Please consider and decide the following:

1. Not implement a 25% admission limit, if not for all free-standing LTACHS, at least for rural, underserved, and other areas with less than four equivalent sized general hospitals; or
2. If the 25% rule for free-standing hospitals is implemented, permanently grandfather existing LTACHs and hospitals currently being constructed to become LTACHs.

This would provide sensible governing:

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provide and the will of Congress to fairly pay for LTACH services. The Congress, the LTACH industry, MedPAC, and RTI International (which recently provided a report to CMS on LTACHs) all agree that LTACHs serve an important role in caring for medically complex patients who need long-term hospital stays. The combined effect of this proposed rule makes clear that CMS does not agree with this most basic premise. These proposed policies will continue to erode the LTACH PPS by reimbursing LTACHs for fewer and fewer medically complex patients at the LTACH PPS rates.

7. CMS must implement an LTACH PPS that fairly reimburses LTACHs for the costs they incur in caring for Medicare beneficiaries, in keeping with the statutory mandate of Congress. The proposed changes to the regulations will bring LTACH reimbursement below their cost of care.

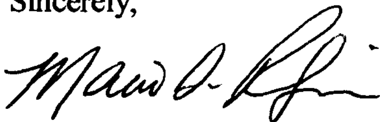
Conclusion

The 25% admission from any one hospital policy will have a disparate impact on LTACHs in areas without at least four equivalent referral hospitals – primarily underserved, rural and other nonurban markets – that is not appropriately accounted for with the limited number of exceptions to the 25% rule. CMS should not extend the current 25% rule, or any similar policy, to freestanding LTACHs or grandfathered LTACHs. However, if CMS finalizes this policy, it should:

(1) Grandfather all existing and under-development freestanding LTAC hospitals from the rule altogether, and
(2) Set the applicable percentage for all new freestanding LTACHs at 50% in light of the lesser policy concerns CMS has with these hospitals as compared to co-located LTACHs, and
(3) Exclude rural areas and other cities with less than 4 equivalent hospitals from the 25% rule.

Thank you for your attention to the important considerations related to LTAC hospitals raised in this letter.

Sincerely,



Mario A. Rodriguez
14943 Dancers Image
San Antonio, Texas 78248

110 N. Elm Avenue
Jackson, MI 49202-3595
(517) 787.1440

22

CareLink of Jackson

A community-owned specialty hospital

March 20, 2007

VIA FEDERAL EXPRESS

Centers for Medicare & Medicaid Services
U.S. 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; 72 *Fed. Reg.* 4,776 *et seq.* (Feb. 1, 2007); CMS-1529-P.

Dear Sir or Madam:

On behalf of CareLink of Jackson ("CareLink"), please accept these comments concerning **"Other Proposed Policy Changes for the 2008 LTCH PPS Rate Year,"** specifically the proposed expansion of the "25 percent rule."

CareLink is a member of the Acute Long Term Hospital Association ("ALTHA"). In deference to your time and attention, we are not addressing numerous concerns that we have with the proposed rule, including, for example, the proposed adjustment for high-cost outliers, which are thoroughly addressed in the comments submitted by ALTHA. Instead, this letter focuses on the proposed change of greatest impact and concern to our community: the proposed expansion of the 25 percent rule. Nonetheless, we urge the Centers for Medicare & Medicaid Services ("CMS") to consider carefully the comments submitted by ALTHA, which we endorse in their entirety.

CareLink respectfully requests that CMS modify its proposed expansion of the 25 percent rule. As currently drafted, the rule does not adequately take into account the unique situation of long term care hospitals ("LTCHs") located in single hospital metropolitan statistical areas ("MSAs"). We believe there are a number of alternatives that would effectively address CMS's concerns regarding LTCH referrals that would be less onerous on this small number of LTCHs, including the following:

- Exempt *freestanding* LTCHs located in single hospital MSAs from the 25 percent rule;
- Grandfather *freestanding* LTCHs currently operating in single hospital MSAs;

- Exempt LTCHs based on distance to next nearest facilities; or
- Increase the admission threshold to 75 percent.

Each of these alternatives is discussed in more detail below. Unless the current proposal is modified, CareLink will be unable to cover the costs of treating its critically ill patients, and it will most likely have to close its facility. While we recognize that CMS hears statements of this magnitude often, we assure you that this is not hyperbole.

CareLink of Jackson

CareLink is a not-for-profit LTCH located in Jackson, Michigan, and in the Jackson, Michigan MSA. CareLink is licensed for 64 beds. CareLink provides services for medically complex patients, who require specialized care and a longer length of stay than offered by traditional short-term acute care hospitals. CareLink offers programs in cardiopulmonary care, renal/dialysis, ventilator weaning, and wound care to patients who are commonly diagnosed with the following diseases and conditions: cardiovascular heart-related illnesses, catastrophic injuries, complex orthopedic injuries, infectious disease, malnutrition, kidney and other organ failure, respiratory disease, serious wounds, surgical complications, and numerous other co-morbidities. Many CareLink patients are treated not only for their primary illness, but also for a secondary set of health issues, such as infection or nutritional and metabolic problems. The vast majority, 95 percent, of CareLink's patients are Medicare beneficiaries.[1]

CareLink is jointly owned by Foote Health System, also of Jackson, and Borgess Health of Kalamazoo. Nonetheless, CareLink operates under its own provider number and wholly independently from either W.A. Foote Memorial Hospital ("Foote Hospital") or Borgess Medical Center, the flagship short-term acute care facilities associated with these systems. An independent board oversees CareLink's operations, the facility has its own medical staff, and it is not a department of either hospital. CareLink is located in close proximity (approximately 0.75 miles) to the Foote Hospital campus, but CareLink is a freestanding facility that is *not* located on Foote Hospital's campus.

Short- and Long-term Acute Care Hospital Services in Jackson and Surrounding Areas

The Jackson MSA is a single county MSA comprised solely of Jackson County. The Jackson MSA is located in south-central Michigan between and contiguous to the Ann Arbor, Detroit-Warren-Livonia, Lansing-East Lansing and Battle Creek MSAs.[2] Although qualifying for MSA status, Jackson County is lightly populated with only approximately 164,000 residents spread over more than 700 square miles (*i.e.*, 232 persons per square mile). Nearly 13 percent of the population is over 65 years-old.

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1 Michigan's Medicaid Program does not cover transfers from one acute care hospital to another.
2 Exhibit A attached shows the location of the Jackson MSA and surrounding MSAs in Michigan.

CareLink is the only provider of long-term acute care services in the MSA, and the only LTCH between Ann Arbor, Lansing and Battle Creek. The next nearest LTCH is nearly 40 miles from CareLink.

Not only is CareLink isolated from surrounding LTCHs, it also is isolated from other short-term acute care hospitals. Foote Hospital is the only short-term acute care facility in the MSA. The next closest short-term acute care hospitals to CareLink are Chelsea Community Hospital in Chelsea, Eaton Rapids Community Hospital in Eaton Rapids, and Hillsdale Community Health Center in Hillsdale. These facilities are located approximately 23 miles, 30 miles and 39 miles, respectively, from CareLink. Of course, there are a number of short-term acute care hospitals, as well as LTCHs, located in Lansing, Ann Arbor and Battle Creek, but these facilities all are approximately 40-45 miles from CareLink.[3] Exhibit B attached shows the locations of CareLink, Foote Hospital, and these and other surrounding short-term acute care hospitals and LTCHs in southern Michigan.

Historically, more than 90 percent of patient admissions at CareLink are discharges from Foote Hospital; similarly, more than 95 percent of discharges from Foote Hospital needing long-term care services receive those services at CareLink. This mutual co-dependence is easily explained. First, given the proximity of CareLink to Foote and the fact that Foote Hospital is the only hospital in the Jackson MSA, it is not surprising that Foote Hospital refers the majority of its patients needing long-term acute care to CareLink, or that the vast majority of CareLink's admissions are from this single facility.

Second, given the size of Foote Hospital, especially as compared to the size of surrounding facilities, it also is not surprising that virtually all of CareLink's admissions are from this one facility. According to CMS's own fiscal year 2007 impact file, Foote Hospital has nearly 350 beds and an average daily census of nearly 200 patients. Foote Hospital is more than twice as large as Chelsea Community Hospital (68 beds), Eaton Rapids Community Hospital (20 beds) and Hillsdale Community Health Center (56 beds) combined. Even if these three hospitals referred all of their patients needing long-term acute care services to CareLink, the number of patients admitted from Foote Hospital would still comprise the vast majority of admissions to CareLink.

Third, the presence of other short-term acute care facilities and LTCHs in the more densely-populated urban centers of southern Michigan provides another obstacle to any efforts by CareLink to expand its referral sources. For instance, Chelsea Community Hospital, the closest short-term acute care hospital to CareLink, is located between Jackson and Ann Arbor, but closer to Ann Arbor. Chelsea sends the vast majority of its patients needing long-term care to the Select Specialty Hospital LTCH in Ann Arbor, because it is far more convenient for many of its

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[3] The University of Michigan Medical Center, with 744 beds, St. Joseph's Mercy Hospital, with 472 beds, and the VA Medical Center, with 155 beds, are located in Ann Arbor, which is approximately 40 miles to the east of Jackson. Lansing, located approximately 40 miles to the north of Jackson, has two large acute care facilities: Ingham Regional Medical Center with 332 beds, and Sparrow Health System, with 733 beds. To the west, Battle Creek Health System in Battle Creek has 382 beds and is approximately 45 miles from CareLink.

patients and their families, especially those living east of Chelsea, to receive long-term acute care services in Ann Arbor than in Jackson.[4] Patients from the largest hospitals in Ann Arbor, Lansing, and Battle Creek naturally are referred to LTCHs in those communities.[5]

Effect of the Proposed Rule on CareLink

As an LTCH in a single hospital MSA, CareLink would be subject under the proposed rule to a payment adjustment based upon a 50 percent admission threshold. The geographic factors described above make it impossible for CareLink to significantly change current admission patterns, and even the higher 50 percent threshold for LTCHs located in single hospital MSAs would be devastating to CareLink. Specifically, we estimate that nearly 25 percent of our patient admissions (after taking into account exclusions based on discharges that qualify as outliers at Foote) would be subject to the payment penalty, and that CareLink would lose approximately $1.9 million in gross revenue Medicare payments as a result of this change alone.

CareLink also expects to be hit hard by other proposed payment changes. For example, we estimate that CMS's proposed changes to the short-stay outlier payment policy, if implemented, would further reduce payments by approximately $84,000, while CMS's proposed changes to the high-cost outlier threshold, if implemented, would reduce payments by approximately $526,000. Together, these three changes would reduce CareLink's top-line Medicare payments by more than $2.5 million.

Because nearly all (95 percent) of CareLink's patient service revenues come from Medicare, CareLink cannot offset these losses by diversifying its payor mix. Prior to seeing CMS's proposal, CareLink anticipated a $350,000 net gain for its fiscal year 2007, for a net operating margin of approximately 3.4 percent. A loss of $2.5 million equates to nearly 24 percent of CareLink's total patient care revenues, and would result in a net loss of more than $2.1 million, or nearly 20 percent.

It is no exaggeration to say CareLink cannot withstand a $2.1 million loss. Without Medicare payments sufficient to cover the costs of the expensive care the facility provides to beneficiaries, it will be nearly impossible for CareLink to sustain its operations. Regrettably, this payment reduction likely will cause the Foote and Borgess health systems to consider closing CareLink. Without CareLink as a long-term care option for Medicare beneficiaries and other patients in the Jackson area, patients discharged from Foote who need long-term acute care services will be transferred to LTCHs that are 40 miles or more from Jackson. Distance of this magnitude between patients and their families compromises treatment effectiveness and recovery, and increases costs for the institutions that provide long-term care services.

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[4] Similarly, Eaton Rapids Community Hospital, the third closest acute care facility to CareLink, is located closer to Lansing than to Jackson. Patients admitted to LTCHs upon discharge from this facility are generally admitted to Sparrow Specialty Hospital in Lansing.

[5] Underscoring the fact that it is geography – and not ownership – that drives referrals to CareLink is the fact that, despite the relationship of Borgess Health to CareLink, none of CareLink's referrals are from Borgess Medical Center. Borgess Medical Center is located 40 miles from CareLink.

Alternatives to the Proposed Expansion of the 25 Percent Rule

There are several alternative approaches that would effectively address CMS's concerns, and that would be less onerous for LTCHs located in single hospital MSAs. In developing these proposals, CareLink was mindful of CMS's responsibility to limit unnecessary costs to the Medicare program.

1. Exempt freestanding LTCHs in single-hospital MSAs from the 25 percent rule.

As a general matter, for all the reasons explained in ALTHA's comments, CareLink believes that CMS should not extend the 25 percent rule to freestanding facilities. Nonetheless, if CMS implements this policy change, for the following reasons, it should exempt freestanding LTCHs in single-hospital MSAs.

First, LTCHs in single-hospital MSAs face unique issues that distinguish these facilities from LTCHs in rural and or dominant-hospital areas, and that make compliance with the 25 percent rule impossible. In crafting its current rule imposing a 25 percent admission threshold on co-located hospitals, CMS included a limited exception for certain LTCHs, including those located in single-hospital MSAs. For these hospitals, a threshold of up to 50 percent may apply. The proposed rule sets forth the same exceptions for freestanding LTCHs that are located in rural and urban single or MSA-dominant hospital areas. CareLink appreciates that CMS recognizes the "unique needs of these communities." 72 *Fed. Reg.* 4,776, 4,810 (Feb. 1, 2007). However, CMS may not fully appreciate the differences between LTCHs located in areas with only one short term acute care hospital, and LTCHs located in areas with only a few hospitals, like rural and MSA-dominant hospital areas.

An area with an MSA-dominant hospital will also be home to at least one other short-term acute care facility. As such, LTCHs in these areas can necessarily receive patients from more than one short-term acute care hospital. Although it is possible that well over 50 percent of the Medicare discharges in the MSA may come from a single "dominant" hospital, the 50 percent rule is a more reasonable policy in these circumstances, because the LTCH more likely has the flexibility to diversify its admissions practices to accommodate the threshold.

LTCHs located in single hospital MSAs, on the other hand, have no such flexibility. LTCHs in areas with only one short-term acute care hospital will tend to have only one facility from which to admit patients. While LTCHs located in areas with MSA-dominant hospitals can potentially alter their outreach to nearby hospitals to respond to the proposed rule, LTCHs located in single hospital MSAs cannot. By definition, a single hospital MSA has only one short-term acute care facility within the MSA, which will logically be the primary – if not only – referral source for the LTCH. These LTCHs simply cannot affect the percent of patient admissions coming from the nearby short-term acute care hospital.

Second, applying the 25 percent rule to freestanding LTCHs in single hospital MSAs is contrary to congressional intent. Congress established the LTCH designation and its separate benefits to identify and buttress hospitals like CareLink that, by reason of their case mix, are critical to the

healthcare infrastructure of their communities and are financially vulnerable. LTCHs are excluded from the inpatient prospective payment system ("IPPS") "because they typically treat[] cases that involve[] stays that [are], on average, longer or more costly than would be predicted under the [inpatient] DRG system." 67 *Fed. Reg.* 13,416, 13,418 (March 22, 2002) (proposed rule). The inpatient "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." *Id.* (citing the Report of the Committee on Ways and Means, U.S. House of Representatives, to Accompany H.R. 1900, H.R. Rept. No. 98-25, at 141 (1983)). LTCHs "could be systemically underpaid if the same DRG system were applied to them." 67 *Fed. Reg.* at 13,418.

In 1997, when Congress revised the payment structure for LTCHs, it established a separate LTCH prospective payment system ("PPS") "to account for different resource use of long-term care hospital patients." 67 *Fed. Reg.* 55,954, 55,955 (Aug 30, 2002) (final rule establishing the LTCH PPS). The creation of an LTCH PPS confirmed that Congress recognizes that care provided by LTCHs to Medicare beneficiaries is costlier than the care generally provided by short-term acute care facilities and paid for under the IPPS.

Under the proposed rule, it is inevitable that a significant portion of the costs of treating Medicare beneficiaries at CareLink will be reimbursed under the IPPS, and not under the LTCH PPS. Applying a 50 percent threshold to LTCHs located in single hospital MSAs would strip these hospitals of the special status afforded to them by Congress, and thereby undermine the purpose of the LTCH PPS.

Finally, doing so would have minimal cost impact on the Medicare program. According to our analysis, there are only three other LTCHs located in single-hospital MSAs.

LTCH	PN	City, State	Short-term Acute Care Hospital	PN
Bay Special Care Center	232020	Bay City, MI	Bay Regional Medical Center	230041
Highsmith Rainey Memorial Hospital	342014	Fayetteville, NC	Cape Fear Valley Medical Center	340028
SCCI Hospital-Mansfield	362021	Mansfield, OH	MedCentral Health System	360118

Two of the other LTCHs are co-located with their companion hospital, and therefore are already subject to the 25 percent rule, at least to the extent that it is currently applied during the transition. Bay Special Care Center is co-located with its companion hospital, but is eligible for grandfather protection, and so it is not presently subject to the 25 percent rule. For the foregoing reasons, CareLink believes that CMS should exempt all LTCHs in single hospital MSAs from the 25 percent rule. If CMS were to agree, and exempt all four of these hospitals from this policy, the additional cost to Medicare would be nominal. If CMS were to decide to maintain current policy, and simply refrain from extending this policy to freestanding and grandfathered LTCHs in single hospital MSAs, we estimate that only two LTCHs, CareLink and Bay Special Care Center, would be affected, and that the total program impact would be minimal.

2. Grandfather LTCHs currently operating freestanding facilities in single hospital MSAs.

CMS has a long history of excepting hospitals operating at the time of a major policy change from the new change. This is especially true with respect to LTCHs, where CMS has traditionally exempted facilities that were excluded from the IPPS on or before September 30, 1995 and that continue to meet certain criteria. *See* 42 C.F.R. § 412.22(f). CMS provided these exceptions "to protect existing hospitals from potentially adverse impact" resulting from policy changes. 68 *Fed. Reg.* 45,157, 45,463 (Aug 1, 2003).

CMS's proposed policy change would without question adversely impact CareLink, and likewise probably would adversely impact other similarly situated facilities. Moreover, CareLink has demonstrated that it has no flexibility to adjust its admissions practices to accommodate the policy change. Similarly situated LTCHs also would have no such flexibility. For these reasons, CMS's proposed policy change is far more appropriately applied to new facilities that can adequately consider the impact of this policy in deciding whether and where to locate. For these reasons, CMS should implement this policy on a going forward basis only, and grandfather existing LTCHs.

3. Exempt LTCHs based on distance to next nearest LTCH.

Alternatively or additionally, CMS could exempt LTCHs based on their distance from other LTCHs. Identifying facilities for an exception based on distance would achieve two policy objectives. First, it would identify instances where patients and their families would have to travel great, and perhaps unreasonable, distances to receive long-term care services, and where an onerous payment policy that forces an LTCH to limit patient admissions or potentially close would cause extraordinary hardship for the community. Second, it would identify situations where short-term acute care hospitals have limited referral options for patients needing long-term care.

An appropriate distance between LTCHs for purposes of this policy might be 35 miles. Congress and CMS have routinely recognized 35 miles (*e.g.*, sole community hospitals and critical access hospitals) as a significant and perhaps unreasonable distance to travel for healthcare services.

CMS could use a distance requirement to determine whether to exempt facilities from the 25 percent rule, or require LTCHs to be in a single hospital area and at least 35 miles from another LTCH to be exempt from the 25 percent rule.

4. Increase the patient admission threshold.

If CMS decides that some threshold is required for LTCHs located in single hospital MSAs, it should first study the referral admission experiences of these LTCHs and determine an admission threshold based on empirical evidence. Based on our own analysis, a 75 percent threshold would be more reasonable than the proposed 50 percent level. A 75 percent threshold would achieve

CMS's policy objective of reducing "gaming" of the IPPS while lessening the impact of the policy change. In addition, setting this higher threshold would acknowledge that LTCHs in single hospital MSAs face greater challenges in altering the percentage of referrals from feeder hospitals than do their counterparts situated in areas with MSA-dominant hospitals.

Additional Improvements to the 25 percent Rule

Regardless of what CMS decides with respect to the alternatives suggested above, the agency should exempt from the applicable threshold cases that exceed a threshold length of stay at the referring short-term acute care hospital.

The 25 percent rule is premised on CMS's interest in "protect[ing] the integrity of the IPPS by ensuring that...costly, long-stay patients who could reasonably continue treatment in an acute care hospital would not be unnecessarily discharged to an onsite LTCH, a behavior that would undermine the Medicare IPPS DRG payment system for acute care hospitals." 72 *Fed. Reg.* at 4,809. CMS determined that it could achieve this policy goal while excluding patients transferred from the host hospital that had already qualified for outlier payments at the host.

CMS could likewise continue to achieve its policy objective and exclude from the count other comparable discharges where the patient has stayed <u>at least</u> the full length-of-stay envisioned by the DRG. In these instances, the beneficiary receives at least the full course of treatment at the short-term acute care hospital before being discharged. We are not proposing a specific threshold here, but envision that CMS has a number of options, such as measures based on DRG length-of-stay data or on the old day outlier policy, that would enable the agency to adequately achieve its policy objective of protecting the integrity of the IPPS.

Transition

When CMS imposed the 25 percent rule on co-located facilities, it phased in the payment policy over a four-year period. The first year of the transition period was a "hold harmless" year based on the percentage of Medicare discharges from the host hospital in the previous year. In year two, the percentage of Medicare discharges that could be admitted from the host with no adjustment could not exceed the lesser of the percentage of the discharges admitted from the host prior to implementation of the 25 percent rule, or 75 percent. In the third year, the threshold was reduced to 50 percent. Finally, during the fourth year, hospitals that did not qualify for the 50 percent maximum threshold will be finally subject to the 25 percent cap.

Curiously, CMS did not propose any kind of phase-in for this expansion of the policy, even though it has caught many facilities by surprise and would cause considerable hardship. Under CMS's proposal, the expansion of the 25 percent rule would be effective July 1, 2007, with no transition period.

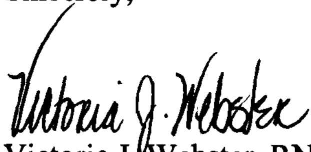
If CMS decides to impose an admission threshold for LTCHs located in single hospital MSAs, regardless of what that threshold is, it should use a similar 4-year transition for affected LTCHs. Similar to the structure of the current transition period for co-located facilities, CareLink

proposes that the first year of the transition be a "hold harmless" year, based on the percentage of Medicare discharges from the host hospital in the previous year.

* * * * *

Thank you for considering these comments. If you have any questions, please call me at (517) 796-4426, or our Washington Counsel, Eric Zimmerman, at (202) 756-8148.

Sincerely,



Victoria J. Webster, RN, BSN, MPA
Vice President and Chief Operating Officer

Enclosures
cc: Eric Zimmerman, McDermott Will & Emery, LLP

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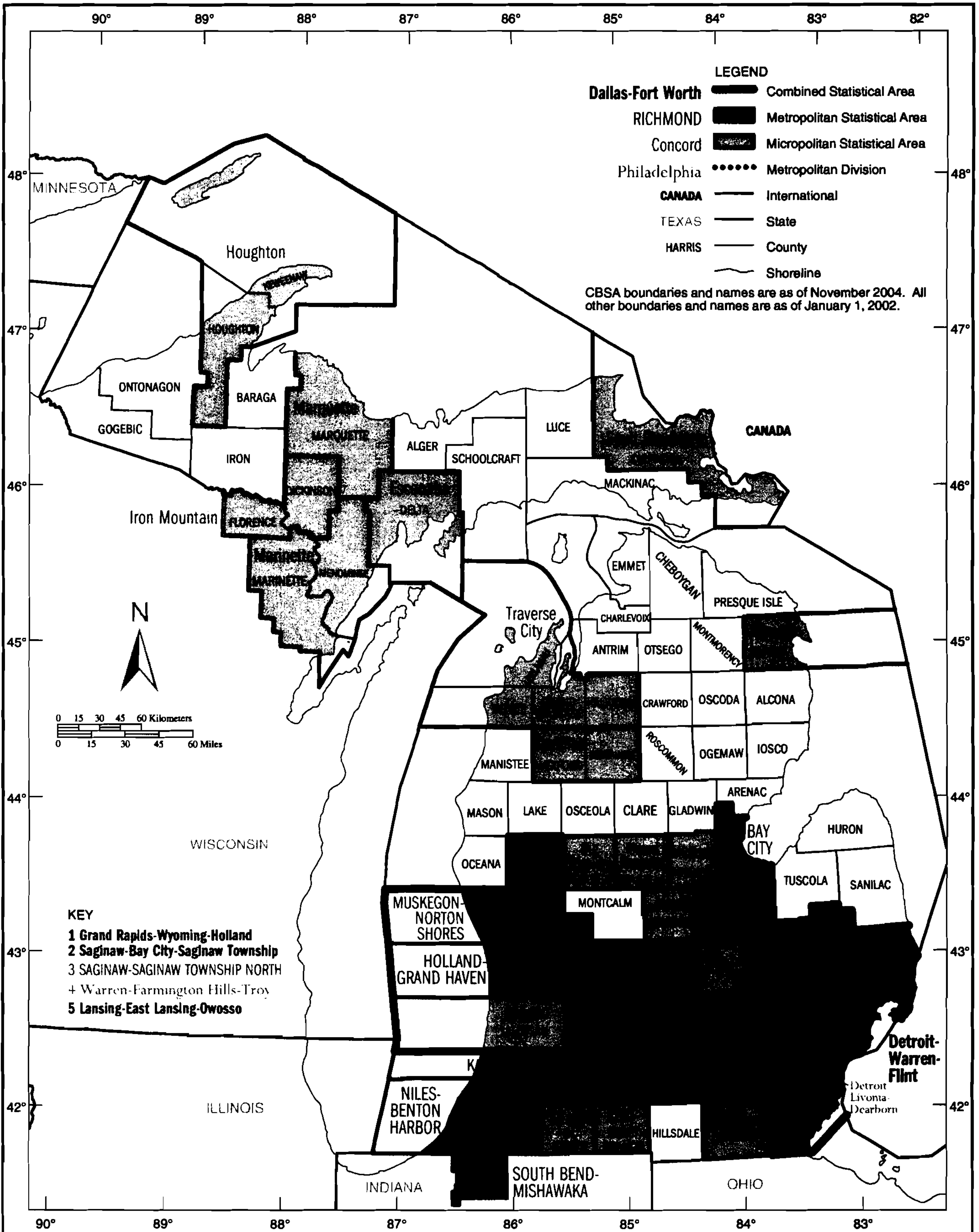
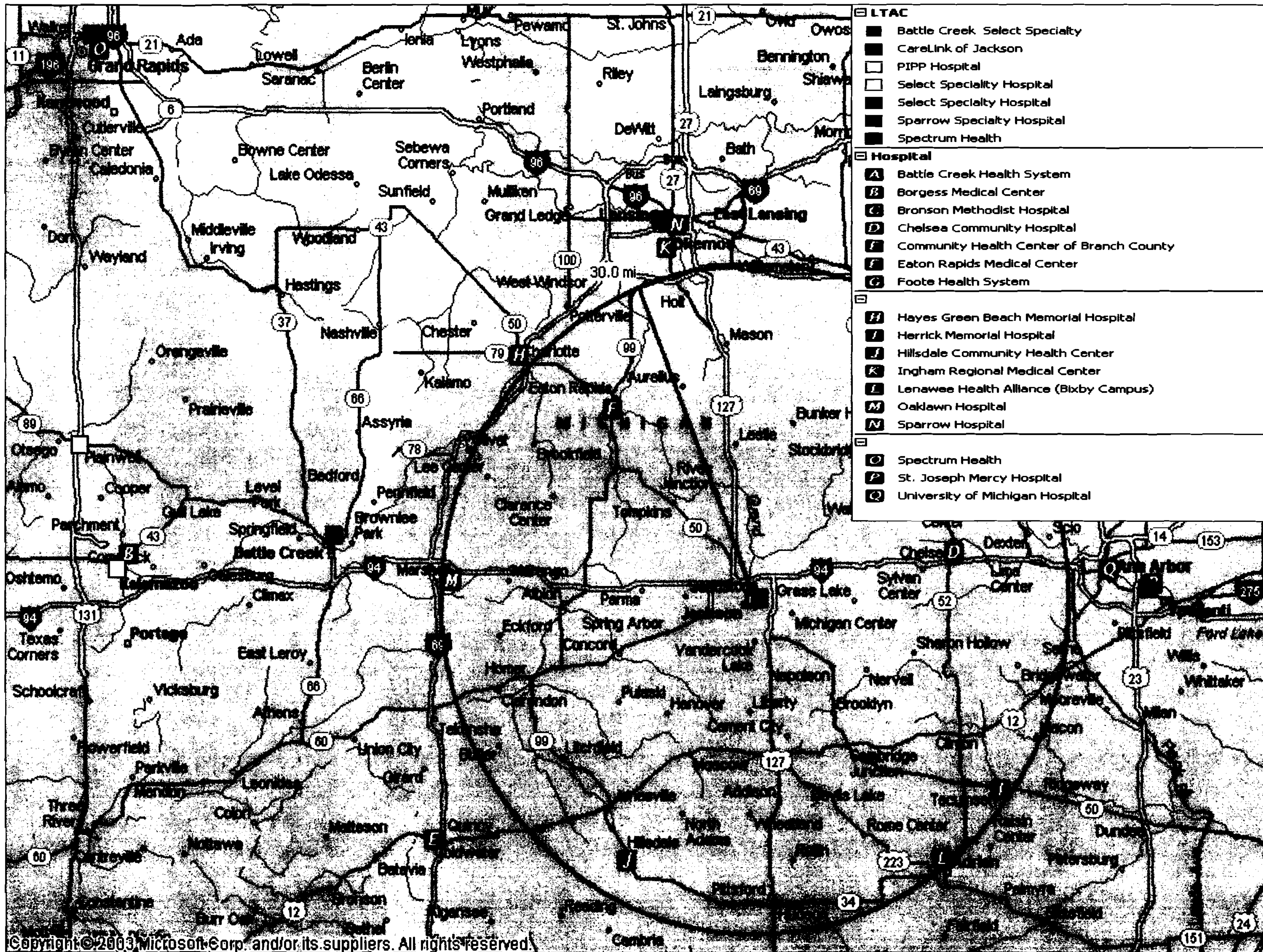
MICHIGAN - Core Based Statistical Areas and Counties





LTAC
Battle Creek Select Specialty
CareLink of Jackson
PIPP Hospital
Select Specialty Hospital
Select Specialty Hospital
Sparrow Specialty Hospital
Spectrum Health
Hospital
Battle Creek Health System
Borgess Medical Center
Bronson Methodist Hospital
Chelsea Community Hospital
Community Health Center of Branch County
Eaton Rapids Medical Center
Foote Health System
Hayes Green Beach Memorial Hospital
Herrick Memorial Hospital
Hillsdale Community Health Center
Ingham Regional Medical Center
Lenawee Health Alliance (Bixby Campus)
Oaklawn Hospital
Sparrow Hospital
Spectrum Health
St. Joseph Mercy Hospital
University of Michigan Hospital
30.0 mi
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March 21, 2007

BY 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.

Vibra 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. Vibra has analyzed the proposed rule and found that it suffers from a number of recurring problems which are outlined in the ALTHA response to the proposed rules. In addition to participation in the ALTHA response, Vibra wishes to highlight one specific hospital impacted by the extending of the "25% rule" from hospitals-within-hospitals ("HIHs") to all LTACHs. CMS should reconsider its proposed policy for extending the so-called "25% rule" from, 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.

Vibra owns a hospital, Kentfield Hospital, located in Marin County that is significantly impacted by the change in the 25% rule. Marin County is located near San Francisco but is separate and uniquely segregated from the greater San Francisco area by the Golden Gate Bridge. Because of its proximity to the metropolitan area it is grouped into that urban area. The hospital receives the majority of its patients from Marin General Hospital which is the only other hospital located in Marin County. Based on the proposed rules 25% rules applying to free

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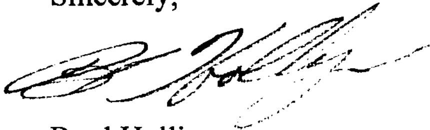
standing hospitals this hospital will unfairly and arbitrarily impact the ability of Kentfield Hospital to provide care to Medicare patients in Marin County.

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,



Brad Hollinger
Chief Executive Officer
Vibra Healthcare

Attachment #23

CMS questions that come out of the new proposed regulations

The overriding philosophy of the one payment incident of care

- This approach elevates reimbursement policy over the patient need for care. This should not be the overriding philosophy of the Medicare program.
- Because CMS does not rebase the cost of patient care on a regular basis, using a one payment incident of care is an unfair and failed policy.
- This approach ignores the broad policy issues affecting the growth of the LTACH level of care and therefore will fail
  - Full – high census in acute short stay hospitals
  - Need to create through put to keep limited ICU beds available for use
  - The difference in patient care culture required by the patient and demonstrated by the comparison of the short term stay vs. the long term stay hospital. Incident of care vs. team approach.
  - The geometric mean and cost outlier system is a financial model and not a clinical need model
  - Acute hospitals have limited capital and the cost of health care construction is limiting new expansion.
  - There are limited staffing resources in the acute short stay hospital.

The 25% rule for freestanding LTACH

- Philosophically this concept is not appropriate and does not ensure better placement of patients into the correct level of care but only limits access to LTACH patients. It does this in an inconsistent and disproportional way without any regard to the patients needs. It is clearly a quota system.

- The rational of the MSA classification system does not even relate to the need for care for LTACH patients. First the purpose of the MSA classification is to define population cohorts and not to define patient's needs. The system is administered by the OMB and not CMS.

- The mechanics of the MSA classification system is not flexible enough to use to set reimbursement policy. How will MSAs be determined, updated, revised and adjusted. When will these updates be revised and when will they impact the reimbursement of the hospitals and their reimbursement. If a hospital gets included or excluded based on where the line is drawn what appeal and review process will the provider have to use?

  Examples:

  Any Hospital

  If we have an LTACH that is on the outskirt of an MSA now and has a market dominate provider what happens if the MSA changes and it is no longer a market dominate provider.

Kentfield CA

If we have an LTACH that is isolated from the MSA that has a market dominate hospital within its county but not within the MSA because it is very large how will this situation be handled.

Market dominant hospital

- How do we determine if we have a market dominate hospital in our MSA?
  - Who will make this determination and certify it is correct?
  - Who will change the classification from year to year and how will this be done? What date will be used to make the change effective and how will that be communicated?
  - How will these decisions affect the timing/impact on reimbursement?
  - Technical issues:
    - What if several hospitals share the same provider number?
    - What if these hospitals are not all in the same MSA?
    - Once you are a market dominant hospital are you dominant until the next year or does this change through out the year?
  - Are these rules set for Hospital within Hospitals now? If so where are these rules posted.
  - There are hospitals that have regional markets but are not market dominant by definition because of the size of the MSA in which they are located. This is caused because their market share does not align with the MSA they are located in. However the Medicare discharges are to be measured only within their MSA.

Examples:

Redding CA

Mercy Hospital provides a large % of admissions to the Vibra LTACH because they are the regional referral center and pull from a large number of counties in Northern CA. The MSA they are located in is very small and yet they pull from 10 counties and therefore the % of patients that go to the LTACH is quite high.

Redding Market	2005 MC Admissions	% MC Admissions market	VIBRA Hosp. MC Admissions 12 month 2006
Mercy	5413	55%	167 66% Total 74%
Shasta	4014	41%	59 23% Total 26%
Patients Hospital	95	.09%	0
Mayers- Fall River Mills	241	2.5%	0
	Total 9763		Total MC Admits 251 Total MSA 226

New Bedford

Charlton Methodist hospital is another example of this regional situation and a local MSA that does not match up well. In addition, because this hospital shares a provided number with its sister hospitals, it can shift significantly in its % of the market share depending on how the sole provider issue is addressed.

How is the market dominant hospital calculation impacted by the fact that several hospitals are grouped under one sole provider number? What happens if these hospitals change their status and become separate providers? When does this change take effect? What if these hospitals grouped under one provider number are located in a separate MSA?

- In some markets, hospitals are dominant within their county but not dominant within their MSA because the MSA is so large. In addition some MSAs are divided into divisions. Do these divisions have any impact on the market dominant calculation?

Providence/New Bedford/ Falls River	2005 MC Admissions	% MC Admissions market	
Butler- Providence	1091	1.5%	
Fatima- Providence	4677	6.7%	
Rhode Island- Providence	8586	12.2%	11
Roger Williams- Prov.	3314	4.7%	
Miriam- Providence	5029	7.2%	9
Women's & Infants- Prov.	621	.9%	2
Charlton- Falls River (this includes data from St Luke's, New	19173	27%	299 87% MSA 51% Total

Providence/New Bedford/ Falls River	2005 MC Admissions	% MC Admissions market	
Bedford & Toby, Wareham in the Boston MSA)			
St Anne- Falls River	2765	3.9%	15
Sturdy- Attleboro MA	2957	4.2%	1
Morton- Taunton	4142	6%	57
Newport- Newport	2290	3.3%	3
Kent- Warwick	5168	7.4%	2
Landmark- Woonsocket	3098	4.4%	
Memorial- Pawtucket	3020	4.3%	2
South County- Wakefield	2160	3%	
Westerly- Westerly	2083	3%	

Total 70174 Total admits 587
MSA Admits 344

Kentfield

Marin Hospital is a major referral hospital to the Vibra LTACH – Kentfield. While this hospital is geographically and socially isolated from the San Francisco area and dominant within its county of Marin it is not a dominant hospital within the overall MSA of San Francisco.

San Francisco	2005 MC Admissions	% MC Admissions Market	Kentfield MC Admissions & %
Alameda	1378		
Alta Bates- Berk.	4715		
Alta Bates- Summit	5928		1
Arden Woods	35		
Calif Pac.-Davies	1545		4
Calif Pac.-Pacific	6231		
Chinese	1265		
Contra Costa	1246		
Doctors	3022		1
Eden	2834		
Fremont	563		
Highland	1816		
John Muir- Concord	3912		3
John Muir- Walnut	6815		
Kaiser-Hayward	679		
Kaiser-Oakland	1003		
Kaiser-Redwood	254		

San Francisco	2005 MC Admissions	% MC Admissions Market	Kentfield MC Admissions & %
Kaiser-Geary	574		
Kaiser-San Rafael	381		
Kaiser South SF	457		
Kaiser-Walnut	693		
Laguna	76		
Laurel Grove	297		
Marin	4598	4.6%	84 65% total 52.5% MSA
Novato	1080	1%	22 17% total 13.8% MSA
Peninsula	4944		
St Francis	2555		
St Luke	1672		
St Mary	3351		1
St Rose	2325		
San Fran General	2952		1
San Leandro	3112		
San Mateo	773		
San Ramon	1474		
Sequoia	3562		
Seton Medical	4759		
Sutter Delta	2137		
Univ. Of CA	7149	7.1%	12 9.2% total 7.5% MSA
Valley Mem.	2787		
Washington	5742		1
	Total 100691		Total 160 MSA 130

MV Mahoning Valley
HOSPITAL

March 21, 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
750 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:

Mahoning Valley 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 acute care hospitals (LTACHs) as well as payment policies.

Mahoning Valley Hospital was established in June 1999 and serves a significant percentage of Medicare patients primarily from the greater Youngstown/Warren, Ohio area. This demographic area is sometimes referred to as the "Mahoning Valley" area which includes the three (3) counties of Mahoning, Trumbull and Columbiana. The Mahoning Valley area has experienced a steady decline in the general population, primarily in the younger age groups (birth to 40 years of age) because of the out-migration of younger families due to a depressed economy and the high unemployment rate. Interestingly, the elderly population; those 60 years of age and older, is the only demographic segment increasing in number – an indication that the older and elderly populations are not moving away from the area. It should be noted that the entire Mahoning Valley area is serviced by only two (2) short-term acute care hospitals (STACHs).

Mahoning Valley Hospital opposes the arbitrary and inappropriate reductions in LTACH payments that will result if the proposed changes to the LTACH PPS are implemented. After reviewing the proposed rule, Mahoning Valley Hospital has found that it suffers from a number of recurring problems. First, as with other recent rulemaking affecting LTACHs, CMS continues to rely upon materially flawed and incomplete data in developing their proposed changes to LTACH payments for RY 2008. Second, Mahoning Valley Hospital 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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Boardman, OH 44512

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9th Floor/1350 Market Street
Warren, OH 44482

CMS should reconsider its proposed change 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. Mahoning Valley Hospital 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 many LTACHs to continue to provide quality patient care to Medicare beneficiaries. 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 ("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, Mahoning Valley Hospital 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.

Further comments about both the expanded 25% rule and the expanded SSO policy are as follows:

Expanded 25% Rule:

CMS justifies expansion of the 25% rule to all LTACHs, including grandfathered co-located LTACHs and freestanding LTACHs, based on the presumption that the STACHs discharge to the LTACH presumably is a "premature discharge" if the patient has not reached cost outlier status at the STACH. There is no clinical or financial evidence to support CMSs conclusion that the patient is discharged prematurely. RTI, CMSs own contractor investigating these issues, has concluded that it cannot state that LTACHs are substituting for services already paid to IPPS hospitals. Without such evidence the proposal should be withdrawn.

It should also be noted that the proposal to expand the 25% rule fails to recognize the many localities in which LTACHs serve a small number of independent STACHs, such as the Mahoning Valley area, thereby making it impossible for Mahoning Valley Hospital to satisfy the 25% rule.

Mahoning Valley 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 LTACHs.

Expanding the 25% rule to all LTACHs not only will jeopardize patient's 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 LTACHs, thereby preventing access to these unique services by many Medicare beneficiaries.

Expanded SSO Policy:

The expanded SSO policy CMS is considering is contrary to clinical and financial realities. Under the current SSO policy a LTACH will at best receive only its cost for a SSO; there is no incentive for a LTACH to admit a patient who is likely to become a SSO. Under the extreme SSO policy being considered a LTACH 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 LTACHs are able to predict, prior to admission, which patients will become SSOs. There is no way for LTACHs 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 LTACHs at the appropriate level of care based on the medical judgment of their treating physician. It is impossible to prescreen patients and effectively identify which patients may become SSOs. There are a myriad of reasons why a patient admitted to an LTACH 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 a STACH due to a deteriorating condition or a new condition which develops subsequent to their admission to an LTACH. Other patients admitted to LTACHs from STACHs 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.

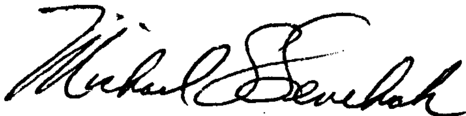
CMS also disregards the fact that a percentage of SSO cases are crossover cases that exhaust Medicare Part A benefits during their LTACH stay. It would be unfair to preclude these Medicare recipients from admission to an LTACH simply based on the number of their remaining Medicare days.

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 LTACHs based on medical necessity, i.e., the need for specific programs of care and services provided in the LTACH.

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 LTACH 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 Sectary Act and 42 C.F.R. §476.71(a).

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

Sincerely,



Michael S. Senchak
President and CEO

Note: Electronically sent 3/21/07
Note: One original and two copies sent via overnight on 3/21/07

CC: Congressman Charlie Wilson, Ohio 6th District, Washington, D.C.
Dan Craig, Deputy Chief of Staff for Congressman Wilson, Washington, D.C.
Dennis Johnson, Local Chief of Staff for Congressman Wilson, Canfield, OH
Congressman Tim Ryan, Ohio 17th District, Washington, D.C.
Ryan Keating, Legislative Director for Congressman Ryan, Washington, D.C.
Pearlette Wigley, Constituent Liaison for Congressman Ryan, Youngstown, OH
Mahoning Valley Hospital Board of Trustees
Mahoning Valley Hospital Medical Executive Committee Members
Mahoning Valley Hospital ALT and MFT Members

2501 Cedar Springs Road, Suite 300, LB 15 Dallas, Texas 75201 214/871-9600 Fax 214/871-3399 1/800-926-2388

March 21, 2007

BY OVERNIGHT MAIL

The Honorable Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1529-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: ***Medicare Program; Prospective Payment System for Long-Term Care Hospitals FY 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:

Upon review of the proposed FY 2008 rule for "long term acute care" (LTAC) hospitals published by CMS on Thursday, February 1, 2007, I have numerous concerns with the proposed regulation. While I understand CMS has concerns about the number of LTAC hospitals, an arbitrary admission quota is not a good answer. The use of clinical admission criteria, as noted in legislation introduced in both the U.S. Senate and House of Representatives, is a much more appropriate methodology to ensure only appropriate patients are treated in LTAC hospitals. As currently proposed, **the 25% threshold on admissions has significant inequities in smaller cities** that have only a few general hospitals. Local LTAC hospital care should not be restricted to only a few very large cities. **The use of an MSA also poses problems**. For example, a city may be 16 or more miles away from a large center city and still be a part of the MSA. The MSA works for wage index as people will drive that far for work. However; patients and their families would like the patient to recover close to home. They do not want to drive 16 miles or more miles when there is an LTCH in their own community. An MSA is too large a statistic. Another complicating issue is that there is usually one very large **tertiary care hospital** in a community. As tertiary care hospitals usually handle the majority of the serious trauma cases, and have more specialized staff and equipment for seriously ill patients, I would assume a large number of LTCH patients would come from the large tertiary care hospitals. Because of the complexity of the healthcare environment, an arbitrary admission policy based on quotas will not work. **All acute care hospitals are not equal. The types of patients treated in them are not the same (severity of illness), and the bed capacity (the ADC) of the hospitals vary significantly. Often times, the very sickest patients are stabilized at one hospital and then transported to one of the larger tertiary care hospitals where they have the appropriate staff and equipment.**

As noted above, CMS proposes a payment penalty for free-standing LTAC hospitals for every patient over a 25% threshold that comes from any single acute care hospital referral source. I have requested clarity on CMS interpretation of the proposed rule. **Per my conversation with CMS staff, it is my understanding the new regulation concerning the 25% threshold will be phased in by cost report year with cost reports beginning on or after 07/01/2007. Therefore, under the proposed regulation, a free-standing LTAC hospital with a Medicare FYE of 05/31/XX will not be subject to the proposed 25% threshold until 06/01/2008. It is also my understanding, based on similar conversations that the 25% threshold is location specific when calculating the threshold for free-standing LTACs. For example, if a short term acute care hospital system had multiple hospitals under one Medicare provider number; the 25% threshold would be applied to each location separately.**

In addition, CMS proposes to revoke "grandfather" status from certain "Hospital within Hospital" LTAC hospitals that have been exempt from this rule. The proposed regulation would limit the way patients are referred to LTAC hospitals, an LTAC hospital could not have more than 25% of its patients referred from any one general hospital.

Noted below are some of the harmful issues that will be caused by the proposed regulation to patients and LTAC hospitals, as well as better options to achieve the same goals:

1. With respect to the proposed rule, the Medicare Payment Advisory Commission (MedPAC) has noted that these referral quotas are a rather crude and unsophisticated approach to dealing with hospital admissions. **These admission quota limits ignore the clinical and quality of care considerations that should be the primary determinant of access to LTAC hospital care.**

2. It has been almost three years since MedPAC called for CMS to create certification criteria to address the growth of the number of LTAC hospitals. **CMS should develop certification criteria for America's LTAC hospitals.**

3. Late last year, CMS received a report from RTI that it commissioned regarding LTAC hospital certification criteria. **The RTI study was generally positive for the LTAC hospital industry, conclusively acknowledging that LTAC hospitals have a legitimate and constructive role in the continuum of American healthcare services.** This proposed CMS quota rule pays little heed to the RTI study which CMS commissioned and funded. **The proposed quota rule will cause many LTAC hospitals to close, especially in underserved and rural areas which have only one or two general hospitals.**

4. In the face of several years of regulatory delays, a number of Members of Congress sponsored legislation to address the criteria issue for LTAC hospitals. In the U.S. Senate, Sen. Kent Conrad and Sen. Orrin Hatch introduced S. 338. In the U.S. House, Rep. Earl Pomeroy (D-ND) and Rep. Phil English (R-PA) sponsored a similar bill, H.R. 562. These bills would establish criteria to define what an LTAC hospital is and which patients should be treated there. They would limit the type of patients who can be treated in an LTAC hospital and reduce Medicare spending on LTAC hospitals by $1-2 billion over five years.

These bills present a rational way to limit spending on LTAC hospitals, as opposed to the 25% rule that will create unnecessary and uneven hardships for patients and hospitals.

5. A few more examples of harm the 25% rule proposal would cause include:

- Loss of local LTACH services in all but large metropolitan areas.
- Fragile patients would have long ambulance rides to access LTACH care.
- Families of patients would have long drives to see loved ones in LTAC Hospitals, for over 25 days average hospitalization
- Patients would have to drive past LTAC hospitals with empty beds in their community and drive to another city to get LTAC care, because of the quotas.
- The 25% quota does not work in Cities with only 1 or 2 acute care hospitals. There is no place for the first 25% of patients to come from, before the matching 25% from the local hospital can be admitted.

An arbitrary percentage (25% or otherwise) on the number of LTACH referrals who will be reasonably reimbursed under the LTACH PPS should not take precedent over 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. These policies discriminate against patients in the 26th percentile and higher and patient care will suffer.

The affect of the existing 25% rule and other changes made over the last three years have not been fully documented yet and CMS does not yet have data to confirm that the policy is achieving the stated policy goals and not having adverse effects on patient care. **The proposed 25% rule expansion will cause the most harm to patients and LTACHs in rural, small cities, cites a long distance from an MSA, and underserved areas. This proposal should be dropped, if not for all free-standing LTACHs, at least for areas that have less than four equivalent short term acute care hospitals.**

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. In addition, the same rationale for creating grandfathered status for PPS-exempt hospitals that were established before the HIH regulations took effect holds true for freestanding LTACHs under the current proposal to extend the 25% rule to them. If CMS finalizes this policy in spite of strong congressional and industry opposition, all existing and under-development freestanding LTACHs should be grandfathered from compliance with the new rule.

<u>Please consider and decide the following:</u>

1. **Not to implement a 25% admission limit, if not for all free-standing LTACHS, at least for rural, small urban, underserved areas, and other areas with less than four equivalent sized general hospitals; or**

2. **If the 25% rule for free-standing hospitals is implemented, permanently grandfather existing LTACHs and hospitals currently being constructed to become LTACHs.**

This would provide sensible governing:

- Appropriate LTACH patients could receive care in their home town, or closer to home, if an LTAC Hospital is already there.
- Patients could be treated by their own doctor, instead of getting a new doctor in the town they have to travel to.
- Families could visit their loved one daily without an extra burden of travel, lodging, meals and other expense and burden.

In addition to the 25% threshold mentioned above, there are other proposed policy changes for which we have concerns:

1. ***Overall Payment Adequacy***. The Medicare Payment Advisory Commission (MedPAC) found that LTAC hospital margins are between 0.1% and 1.9% (MedPAC Report to Congress, March 2007). Yet, CMS projects the proposed rule would reduce payments by 2.9%, which results in rates below the cost of care. In addition, CMS's estimate understates the actual impact by approximately 0.9% because it fails to account for the negative impact of raising the high cost outlier threshold by $3,887 per case. CMS should not propose LTAC hospital rates that fall below the cost of care. The proposed rates are neither reasonable nor adequate given Medicare's goal of covering providers' cost of care. **Furthermore, payments would be reduced by a much greater percentage for LTACHs serving rural and underserved areas that have less than at least three or four general hospitals.**

2. ***Short Stay Outlier Payment Adjustment***. CMS also proposes to pay LTAC hospitals a reduced rate for "very short stay" outlier cases. CMS again justifies this proposal based on the concern that Medicare should not pay twice for a single episode of care. Less than one year ago, CMS finalized a rule that pays LTAC hospitals no greater than cost for all short stay outlier cases. It is too soon to implement further payment adjustments when the new policy has been in effect for less than one year and the impact has not been assessed. LTAC hospitals have no incentives to admit patients that will be "short stay" when LTAC hospitals are already paid no greater than cost for these patients.

3. ***Market Basket Update***. CMS proposes paying LTAC hospitals a 0.71% market basket update, less than the full market basket update of 3.2%, which represents an estimate of actual cost increases experienced by LTAC hospitals. CMS should provide the full market basket increase, especially in light of other payment adjustments, or the cumulative effect of the proposals results in LTAC hospital rates below the cost of care. Nurse and other staff, supplies, and drug costs continue to increase faster than inflation.

4. *LTAC Hospital Certification Criteria.* Legislation has been introduced in the Senate (S. 338) and House (HR 562) to revise LTAC hospital certification criteria to implement MedPAC recommendations of over two years ago. Congress has made it clear that revised LTAC hospital certification criteria, not continued payment cuts, is the preferred policy route to address issues of concern. The proposed rule continues a pattern of arbitrary and punitive payment cuts, based upon questionable assumptions and incomplete or outdated data, which will hurt LTACHs and Medicare beneficiaries. **An approach that would better serve Medicare beneficiaries would be to work together with the LTACH industry and the Congress to develop new certification criteria to better define LTACH facilities and patients to accomplish this goal and help stabilize Medicare reimbursement to LTACHs.**

5. *LTAC Hospital Growth.* CMS continues to raise concerns about growth in the number of LTAC hospitals. However, the cumulative effect of CMS's recent changes and existing payment policies have halted, and possibly reversed, the growth of new LTACHs, and LTACH margins are estimated by MedPAC to be at or near zero. Growth in the number of new LTACHs has stopped.

6. *CMS is interfering with patient choice and the practice of medicine.* The proposed rule greatly restricts patient choice and interferes with the practice of medicine by arbitrarily paying LTACHs at the LTACH payment rate for no more than 25% of its patients referred from any one hospital. This policy also violates the agency's own stated goal to place Medicare patients in the most appropriate post-acute care setting. CMS should implement an LTACH PPS that recognizes the medically complex care LTACHs provide and the will of Congress to fairly pay for LTACH services. The Congress, the LTACH industry, MedPAC, and RTI International (which recently provided a report to CMS on LTACHs) all agree that LTACHs serve an important role in caring for medically complex patients who need long-term hospital stays. These proposed policies will continue to erode the LTACH PPS by reimbursing LTACHs for fewer and fewer medically complex patients at the LTACH PPS rates.

7. CMS must implement an LTACH PPS that fairly reimburses LTACHs for the costs they incur in caring for Medicare beneficiaries, in keeping with the statutory mandate of Congress. The proposed changes to the regulations will bring LTACH reimbursement below their cost of care.

In conclusion, the 25% admission threshold from any one hospital will have a disparate impact on LTACHs in areas without at least four equivalent referral hospitals – primarily underserved, rural and other nonurban markets (The MSA is too large a statistic as noted earlier.) These issues are not appropriately accounted for with the limited number of exceptions to the 25% rule. CMS should not extend the current 25% rule, or any similar policy, to free-standing LTACHs or grandfathered LTACHs. However, if CMS finalizes this policy, it should:

1. Grandfather all existing and under-development free-standing LTAC hospitals from the rule altogether, and

2. Set the applicable percentage for all new free-standing LTACHs at 50% in light of the lesser policy concerns CMS has with these hospitals as compared to co-located LTACHs, and

3. **Exclude rural areas and other cities with less than four equivalent hospitals from the 25% rule**. Cities should be the focus and not MSAs.

Thank you for your attention to the important considerations related to LTAC hospitals raised in this letter.

Sincerely,

Carol A. Daubner
Vice President of Client Financial Services

26

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March 16, 2007

The Honorable Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1529-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: ***Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 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:

I have numerous concerns about the proposed "long term acute care" (LTAC) hospitals regulation the Centers for Medicare and Medicaid Services (CMS) published on January 25, 2007, that introduces significant changes to the way LTAC hospitals are reimbursed by Medicare. While I understand CMS has concerns about the number of LTAC hospitals, an arbitrary admission quota is not an acceptable approach. The use of clinical admission criteria, as included in legislation introduced in both the U.S. Senate and House of Representatives, and called for by Medicare Payment Advisory Commission (MedPAC), is a much more appropriate way to ensure only appropriate patients are treated in LTAC hospitals. CMS' proposal is full of inequity, especially for smaller cities that have only a few general hospitals. Local LTACH care should not be restricted to only a few very large cities.

Comments on the proposed rule are summarized in the following paragraphs:

A. "OTHER PROPOSED POLICY CHANGES FOR THE 2008 LTCH PPS RATE YEAR"

Proposed Extension of 25% Patient Quota Rule to Freestanding LTAC Hospitals. CMS proposes a payment penalty for freestanding LTAC hospitals for every patient over a 25% threshold who comes from any single acute care hospital referral source. In addition, CMS proposes to revoke "grandfather" status from certain "Hospital within Hospital" LTAC hospitals that have been exempt from this rule. The proposed regulation would limit the way patients are referred to LTAC hospitals. An LTAC hospital could not have more than 25% of its patients referred from any one general hospital. I would like to comment on some of the harmful impact to patients and LTAC hospitals the regulation would cause, as well as better options to achieve the same goals:

1. With respect to the proposed rule, MedPAC has noted that these referral quotas are a rather crude and unsophisticated approach to dealing with hospital admissions. No other Medicare-reimbursed facility has to deal with such draconian policies. These admission quota limits, which even MedPAC says are arbitrary, ignore the clinical and quality of

care considerations that should be the primary determinant of access to LTAC hospital care.

2. It has been almost three years since MedPAC called for CMS to create certification criteria to address the growth of the number of LTAC hospitals. Instead of imposing a crude and unfair quota rationing system, CMS should develop certification criteria for America's LTAC hospitals.

3. Late last year, CMS received a report from RTI that it commissioned regarding LTAC hospital certification criteria. The RTI study was generally positive for the LTAC hospital industry, conclusively acknowledging that LTAC hospitals play a legitimate and constructive role in the continuum of American healthcare services. This proposed CMS quota rule pays little heed to the RTI study which CMS commissioned and funded. The proposed quota rule will cause many LTAC hospitals to close, especially in suburban and rural areas which have less than four general hospitals.

4. In the face of several years of regulatory delays, a number of Members of Congress sponsored legislation to address the criteria issue for LTAC hospitals. In the U.S. Senate, Sen. Kent Conrad and Sen. Orrin Hatch introduced S. 338. In the U.S. House, Rep. Earl Pomeroy (D-ND) and Rep. Phil English (R-PA) sponsored a similar bill, H.R. 562. These bills would establish criteria to define what an LTAC hospital is and which patients should be treated there. They would limit the type of patients who can be treated in an LTAC hospital and reduce Medicare spending on LTAC hospitals by $1-2 billion over five years. These bills present a rational way to limit spending on LTAC hospitals as opposed to the 25% rule that will create unnecessary and uneven hardships for patients and hospitals.

5. A few more examples of harm the 25% rule proposal would cause include:
   - Loss of local LTACH services in all but large metropolitan areas.
   - Fragile patients would have long ambulance rides to access LTACH care.
   - Families of patients, including elderly spouses, would have long drives to see loved ones in LTAC Hospitals for over 25 days average hospitalization.
   - Patients would have to drive past the closest LTAC hospital with empty beds in their community and drive to another city to get LTAC care because of the quotas.
   - The 25% quota does not work in cities with less than four acute care hospitals. There is no place for the first 25% of patients to come from before the matching 25% from the local hospital can be admitted.
   - The provision for High Cost Outliers will be difficult to administer since the acute care outlier status is confirmed on payment of the acute care stay.
   - Constant CMS changes lead to healthcare industry instability.
   - The constant annual changing of regulations and reimbursement hurts small businesses that are trying to build long term companies that provide quality healthcare services to very ill patients. Companies cannot plan for the future when CMS significantly changes the regulations every year.
   - Capital commitments have been made by companies to build new hospitals. The 25% rule could cause bankruptcies caused by the inability to service lease payments

and guaranties that were required to get the new hospitals built.

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. These policies discriminate against patients in the 26th percentile and higher and patient care will suffer.

The use of MSAs does not reflect the clinical reality of patient care. Patients referred to their community LTAC are followed by their physician during the LTAC stay. By applying this arbitrary standard, patients will be shifted to whatever LTAC can accept the patient based on the standard. Patients will be treated by physicians unfamiliar with their case, resulting in increased testing and diagnostic procedures and exposing the patient to greater risk. In addition, transportation costs will increase the cost of care for these displaced patients. If CMS implements this baseless standard, use a market definition that reflects the communities served.

The effect of the existing 25% rule and other changes made over the last three years have not been fully documented and CMS does not yet have data to confirm that the policy is achieving the stated policy goals and not having adverse effects on patient care. In fact, the number of LTACs actually declined in 2006 and the phase-in of the HIH 25% rule is not fully implemented. The proposed 25% rule expansion is a draconian quota system that would cause the most harm to patients and LTACHs in suburban, rural, and underserved areas. This proposal should be dropped, if not for all free-standing LTACHs, at least for areas that have less than 4 equivalent Short Term Acute Care (STAC) hospitals.

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. In addition, the same rationale for creating grandfathered status for PPS-exempt hospitals that were established before the HIH regulations took effect holds true for freestanding LTACHs under the current proposal to extend the 25% rule to them. If CMS finalizes this policy in spite of strong congressional and industry opposition, all existing and under-development freestanding LTACHs should be grandfathered from compliance with the new rule.

<u>Please consider and decide the following:</u>

1. Do not implement a 25% admission limit, if not for all free-standing LTACHS, at least for suburban, rural, and other underserved areas with less than four equivalent sized general hospitals; or
2. If the 25% rule for free-standing hospitals is implemented, permanently grandfather existing LTACHs and hospitals currently being developed to become LTACHs.
3. If the 25% rule for free-standing hospitals is implemented, use a community based definition of city in place of the MSA standard.
4. If the 25% rule for free-standing hospitals is implemented, provide for a rural exemption that will allow rural LTACs an opportunity to serve their communities even though they have only one or two STACs in their market.

This would provide sensible governing:

- Companies that have invested in and guaranteed long term hospital leases, based on the rules in existence, would have a chance to survive and meet their obligations.
- Appropriate LTACH patients could receive care in their home town, or closer to home, if an LTAC Hospital is already there.
- Patients could be treated by their own doctor instead of getting a new doctor in the town to which they have to travel.
- Families could visit their loved one daily without an extra burden of travel, lodging, meals, and other expense and burden.

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

1. ***Overall Payment Adequacy***. The Medicare Payment Advisory Commission (MedPAC) found that LTAC hospital margins are between 0.1% and 1.9% (MedPAC Report to Congress, March 2007). Yet, CMS projects the proposed rule would reduce payments by 2.9%, which results in rates below the cost of care. In addition, CMS' estimate understates the actual impact by approximately 0.9% because it fails to account for the negative impact of raising the high cost outlier threshold by $3,887 per case. CMS should not propose LTAC hospital rates that fall below the cost of care. The proposed rates are not reasonable or adequate given Medicare's goal of covering providers' cost of care.

2. ***Short Stay Outlier Payment Adjustment***. CMS also proposes to pay LTAC hospitals a reduced rate for "very short stay" outlier cases. CMS again justifies this proposal based on the concern that Medicare should not pay twice for a single episode of care. Less than one year ago, CMS finalized a rule that pays LTAC hospitals no greater than cost for all short stay outlier cases. It is too soon to implement further payment adjustments when the new policy has been in effect for less than one year and the impact has not been assessed. LTAC hospitals have no incentives to admit patients that will be "short stay" when LTAC hospitals are already paid no greater than cost for these patients.

3. ***Market Basket Update***. CMS proposes paying LTAC hospitals a 0.71% market basket update, less than the full market basket update of 3.2%, which represents an estimate of actual cost increases experienced by LTAC hospitals. CMS should provide the full market basket increase, especially in light of other payment adjustments, or the cumulative effect of the proposals results in LTAC hospital rates below the cost of care. Nurse and other staff, supplies, and drug costs continue to increase faster than inflation.

4. ***LTAC Hospital Certification Criteria***. Legislation has been introduced in the Senate (S. 338) and House (HR 562) to revise LTAC hospital certification criteria to implement MedPAC recommendations of over two years ago. Congress has made it clear that revised LTAC hospital certification criteria, not continued payment cuts, is the preferred policy route to address issues of concern. The proposed rule continues a pattern of arbitrary and punitive payment cuts based upon questionable assumptions and incomplete or outdated data which will hurt LTACHs and Medicare beneficiaries. An approach that would better serve Medicare beneficiaries would be to work together with the LTACH industry and the Congress to develop new certification criteria to better define LTACH facilities and patients to accomplish this goal and help stabilize Medicare reimbursement to LTACHs.

5. ***LTAC Hospital Growth.*** CMS continues to raise concerns about growth in the number of LTAC hospitals. However, the cumulative effect of CMS' recent changes and existing payment policies have halted, and possibly reversed, the growth of new LTACHs, and LTACH margins are estimated by MedPAC to be at or near zero. Growth in the number of new LTACHs has stopped.

6. ***CMS is interfering with patient choice and the practice of medicine.*** The proposed rule greatly restricts patient choice and interferes with the practice of medicine by arbitrarily paying LTACHs at the LTACH payment rate for no more than 25% of its patients referred from any one hospital. This policy also violates the agency's own stated goal to place Medicare patients in the most appropriate post-acute care setting. CMS should implement an LTACH PPS that recognizes the medically complex care LTACHs provide and the will of Congress to fairly pay for LTACH services. The Congress, the LTACH industry, MedPAC, and RTI International (which recently provided a report to CMS on LTACHs) all agree that LTACHs serve an important role in caring for medically complex patients who need long-term hospital stays. The combined effect of this proposed rule makes clear that CMS does not agree with this most basic premise. These proposed policies will continue to erode the LTACH PPS by reimbursing LTACHs for fewer and fewer medically complex patients at the LTACH PPS rates.

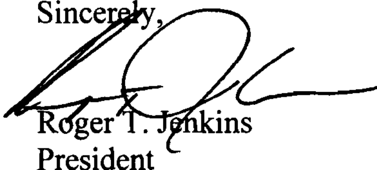
7. CMS must implement an LTACH PPS that fairly reimburses LTACHs for the costs they incur in caring for Medicare beneficiaries in keeping with the statutory mandate of Congress. The proposed changes to the regulations will bring LTACH reimbursement below their cost of care.

Conclusion:
The 25% admission from any one hospital policy will have a disparate impact on LTACHs in areas without at least four equivalent referral hospitals - primarily suburban, rural and other nonurban markets - that is not appropriately accounted for with the limited number of exceptions to the 25% rule. CMS should not extend the current 25% rule, or any similar policy, to freestanding LTACHs or grandfathered LTACHs. However, if CMS finalizes this policy, it should:

1. Grandf ather all existing and under-development freestanding LTAC hospitals from the rule altogether, and
2. Set the applicable percentage for all new freestanding LTACHs at 50% in light of the lesser policy concerns CMS has with these hospitals as compared to co-located LTACHs, and
3. Exclude rural areas and other cities with less than 4 equivalent hospitals from the 25% rule.

Thank you for your attention to the important considerations related to LTAC hospitals raised in this letter.

Sincerely,



Roger T. Jenkins
President

RTJ/mrg/2007.014

27

SAINT BARNABAS HEALTH CARE SYSTEM
MEMORANDUM

TO: Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1529-P

FROM: Rich Henwood RH
Vice President/Corporate Reimbursement
Saint Barnabas Health Care System

RE: ***Payment for Direct Graduate Medical Education***

DATE: March 22, 2007

I am in receipt of the proposed regulations concerning the above and have the following comments or concerns:

1. CMS is proposing this regulation become effective with cost reports beginning on or after July 1, 2007. I am requesting CMS give hospitals the opportunity to prepare this same method for any years where residents were disallowed. In many cases agreements between hospitals and physicians required physicians to invoice hospitals to receive payment. Physicians have not invoiced or confirmed they have no costs (verified by physicians willing to certify). Yet residents are still disallowed because of no payment.

2. CMS is proposing hospitals incur 90% of teaching costs for outside rotations to physicians. I am requesting CMS consider if the physician is willing to sign that he waives any payment. This is part of the regulation. In many cases physicians take this opportunity as a privilege to teach rather than a chore looking for payment.

3. CMS is proposing to use a standard three hours per week as a presumptive number of hours that a teaching physician spends in nonhospital care. Rather having a standard hour CMS should have a standard percentage. If an office is open 40 hours or 60 hours, this should not impact the calculation and still give the hospital the option to get actual data.

4. CMS is proposing the written agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities or specify the total compensation amount the hospital will incur to the nonhospital site to meet the 90%. To spell out this level of detail for every agreement is too burdensome on the hospitals. The agreement should spell out that hospitals agree to incur 90% of costs of teaching residents and show the method. Each payment will have supporting work papers for the audit.

Thank you.

AACOM

American Association of Colleges of Osteopathic Medicine
Office of the President

5550 Friendship Blvd., Suite 310, Chevy Chase, MD 20815-7231 • Phone : (301) 968-4142 • Fax: (301) 968-4101 • www.aacom.org

March 22, 2007

The Honorable Leslie Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1529-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Administrator Norwalk:

On behalf of the American Association of Colleges of Osteopathic Medicine (AACOM), which represents the administrations, faculties, and students of all twenty-three colleges of osteopathic medicine and three branch campuses in the United States, we appreciate the opportunity to present our comments regarding the proposed policy changes under the heading:

> "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. (Feb. 1, 2007)
> (CMS-1529-P)

While we believe the proposed policy changes regarding Graduate Medical Education (GME) represent an important first step in addressing the significant problems occasioned by past CMS policies on training residents in non-hospital settings, much remains to be resolved. AACOM looks forward to working with CMS to effect such a more comprehensive resolution. In the meantime, we request that the agency consider several modifications to the proposed policy changes.

The proposed policy changes would establish several proxies that hospitals could exercise to determine when and how much must be paid to non-hospital settings in order to satisfy CMS' interpretation of the Congressional requirements. Physician payments could be calculated using some or all of these proxies instead of relying on current requirements, which call for 100% payment of an amount based on physician-specific

time and salary information. Under the proposed policy, a hospital could calculate the amount it must pay to a non-hospital setting by using the following formula:

> 0.90 x [(sum of each FTE resident's salary and benefits (including travel and lodging if applicable)) plus the portion of teaching physician compensation attributable to direct Graduate Medical Education activities].

The portion of teaching physician compensation attributable to direct GME activities would be calculated as follows:

> (3/number of hours the nonhospital site is open per week) x (the national average salary for each teaching physician at the site, by specialty.)

The formula is intended to capture training costs in the non-hospital setting, including the time physicians spend in direct GME activities that do not involve patient care.

CMS requires hospitals to pay 100% of these costs based on actual salary and time information to satisfy its current interpretation of the "all or substantially all" mandate. AACOM appreciates the lowering of the cost threshold to 90% from 100% in the proposed policy, but we believe this percentage is still too high. We recommend that CMS lower the threshold to 75%.

Under current CMS policy, teaching hospitals are required to calculate physician supervisory costs based on actual time spent on "non-patient care GME activities" and physician-specific compensation. The proposed policy would provide a proxy using a 3-hour constant to reflect the time physicians spend in non-patient care GME activities on a weekly basis despite the amount of time the resident spends in the setting. Many residents spend less than a full week in particular ambulatory settings. Accordingly, AACOM recommends that the proposed policy reduce the 3-hour presumptive measure of non-patient care GME activities to an amount that more accurately reflects the time physicians spend on the activities on a per resident basis.

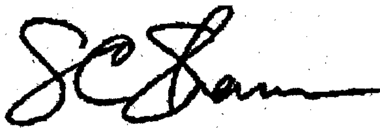
The proposed policy would permit hospitals to use national average compensation data as an alternative to actual compensation on a physician-by-physician basis. This proxy would certainly be an improvement over current rules, which are both burdensome and arbitrary. AACOM recommends that a further improvement would be to allow hospitals to use a comprehensive source of locality adjusted physician compensation information as a proxy for actual compensation in determining non-hospital training costs.

Finally, under current requirements, a hospital must either (a) enter into a written agreement with a non-hospital setting before training begins or (b) pay all or substantially all of the training costs by the end of the third month following the month in which the training occurred. There is no legal requirement that an agreement must be signed before performance of an agreement begins. Where the existence of an agreement is demonstrated by the actions of the parties, the law recognizes an enforceable agreement on the course of dealings. If the existence of a training arrangement can be established

after the fact by concurrent payment, CMS should not deny payment for an agreement that is ratified by the signature of all parties at any time during the agreement. At a minimum, the agency should recognize the presence of a binding agreement as of the time that agreement is executed by all parties.

Again, we appreciate the opportunity to make these comments and look forward to working with CMS to resolve the other underlying problems that challenge both the allopathic and osteopathic medical professions' ability to train residents. If you have any questions, please do not hesitate to contact me.

Sincerely,



Stephen C. Shannon, D.O., M.P.H.
President

cc: Silvia M. Ferretti, D.O., Chair, AACOM Board of Deans
Michael J. Dyer, J.D., AACOM Vice President for Government Relations

OFFICE OF THE DEAN

OFFICE OF POLICY AND PLANNING

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UNIVERSITY OF MARYLAND
SCHOOL OF MEDICINE

March 22, 2007

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

Dear Ms. Norwalk:

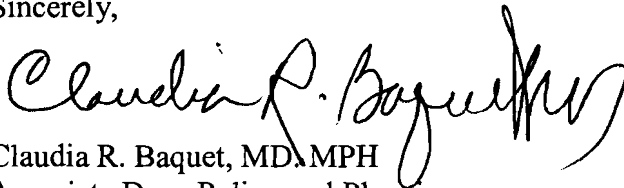
I am writing on behalf of the University of Maryland School of Medicine to comment on the proposed rule published in the Federal Register(72 Fed .Reg. at 4776) on February 1, 2007 regarding Medicare direct medical education (DME) and indirect medical education (IME) payment policy for non-hospital sites. The proposal modifies existing language about graduate medical education (GME) payments to teaching hospitals with respect to payment for the time residents spend training in non-hospital sites, such as physicians' offices. Currently, the Medicare statute authorizes teaching hospitals to receive DME/IME associated with a resident's training in non-hospital sites if the teaching hospital incurs "all or substantially all" of the training costs. Training costs include a resident's stipend and benefits plus physician supervisory costs.

In the past, there has been discussion between the Centers for Medicare and Medicaid Services (CMS) and the Association of American Medical Colleges (AAMC) regarding how to count the time of supervisory physicians who volunteer their time at non-hospital sites. Teaching hospitals and non-teaching hospitals have been frustrated by Medicare documentation requirements that do not recognize the role of unpaid physician volunteers in supervising residents and impose compliance problems due to documentation requirements on the physician's time. These compliance issues can be particularly frustrating in group practices, such as faculty practice plans, where physicians are salaried and it is difficult to sort out supervisory time as compared to billable patient hours. Still, we know it is important to allow residents to experience care-giving in non-hospital settings, particularly in rural areas and urban clinics.

While the proposed regulations, constrained by statutory requirements, do not completely address the issue of volunteer physicians' supervisory time and how to account for it in DME/IME payment, they do provide much needed additional flexibility. By requiring 90% rather than 100% of training costs to be paid for by the teaching hospital, allowing for the use of proxies in calculating comparable physician salary and establishing a presumptive level of time for the supervising physician evaluation activities rather than the actual time at each site, these regulations give administrative relief in recovering DME/IME costs until the Medicare law is clarified. Recognizing that Maryland has a Medicare waiver for a unique all payer hospital rate-setting system for hospital care that sets the same rates at a hospital for all payers, we still conclude that, in general, the proposed regulations are beneficial to most teaching hospitals as they seek to recover costs for training residents in non-hospital sites.

Thank you for the opportunity to comment.

Sincerely,



Claudia R. Baquet, MD, MPH
Associate Dean Policy and Planning,
Professor Medicine, Professor of Epidemiology & Preventive Medicine,
Director, UM NIH Comprehensive Center (Export) for Health Disparities,
Outreach and Training, University of Maryland School of Medicine

SCOTT & WHITE

OFFICE OF GENERAL COUNSEL

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March 21, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1529-P
Mail Stop C4-26-5
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Comments on Proposed LTCH Rule Extension of "25 Percent" Provision
File Code: CMS-1529-P

To Whom It May Concern:

I am writing on behalf of Scott & White to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed long-term acute care (LTCH) PPS rule.

Scott & White, a Central Texas not-for-profit healthcare organization, is an integrated healthcare system with a 503-bed hospital and a clinic with over 550 salaried physicians and scientists with 14 regional clinics throughout Central Texas. This spring, Scott & White will soon open our new freestanding 50-bed LTCH hospital.

We are opposed to any further expansion of the 25 percent admissions cap on LTCH hospitals in the proposed rule. Although CMS is concerned with improper LTCH hospital admissions, further expansion of the cap to freestanding LTCH hospitals would only jeopardize the treatment of legitimate LTCH hospital 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 LTCH hospitals would take post-acute care decisions out of the hands of physicians and could severely jeopardize the treatment of otherwise appropriate LTCH hospital patients.

SCOTT & WHITE CLINIC

SCOTT *and* WHITE MEMORIAL HOSPITAL *and* SCOTT, SHERWOOD *and* BRINDLEY FOUNDATION

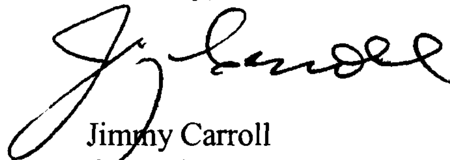
SCOTT *and* WHITE HEALTH PLAN

2401 South 31st St., Temple, Texas 76508 254-724-3001 Fax: 254-724-4501 http://www.sw.org

An alternative to expanding the 25 percent admissions cap would be the implementation of medically based facility and patient criteria. Certification criteria should be developed for LTCH hospitals. This criteria should define appropriate patients for LTCH hospitals by general medical conditions and severity of illness, rather than diagnoses. By doing this, it would help to ensure that patients who are admitted to an LTCH hospital are medically complex. Patients that can be treated in other post-acute settings would not be admitted to LTCH hospitals.

Please do not include the expansion of the 25 percent rule to freestanding LTCH hospitals when the LTCH PPS rule is finalized. Thank you for your consideration of our comments.

Sincerely,



Jimmy Carroll
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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. <u>See</u> 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**
All Discharges				
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%
Discharges to LTACH				
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%
Discharges to Other Destinations				
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.

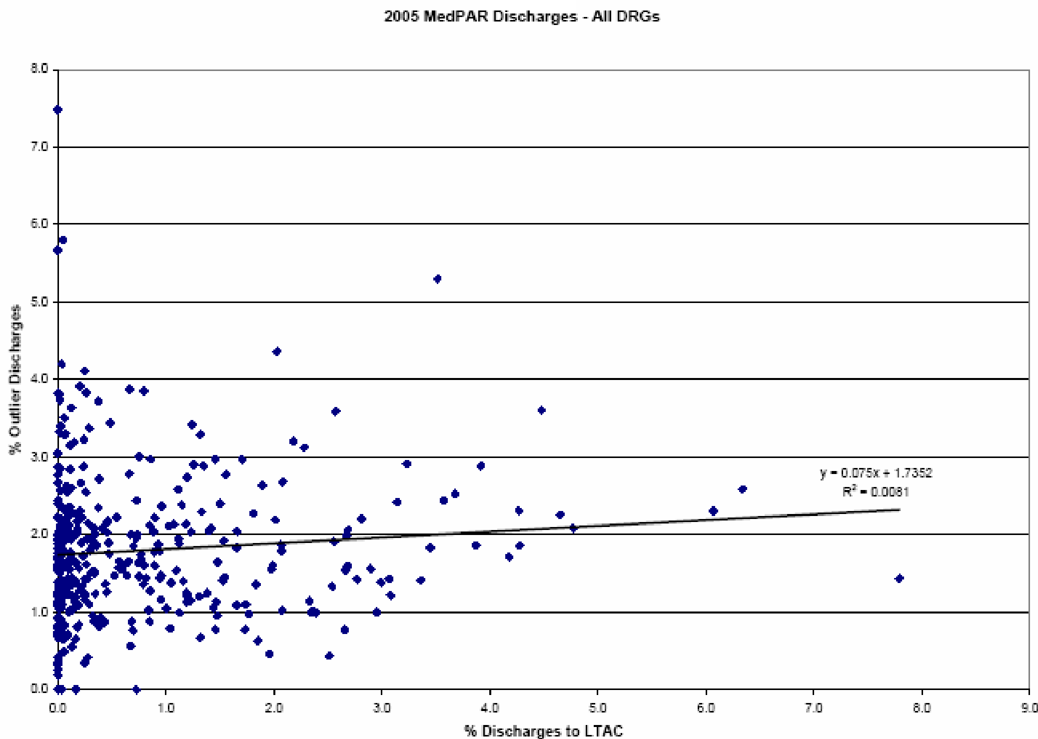
Although not specifically discussed in the rulemaking record, conversations with CMS revealed that another possible justification for the proposal to extend the 25% rule to freestanding LTACHs is the concern that STACHs may be discharging patients "early" to LTACHs, prior to completing episodes of care, 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:

<u>All DRGs</u> (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



<u>Top 10, 20, 30 and 50 Frequency DRGs</u> (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

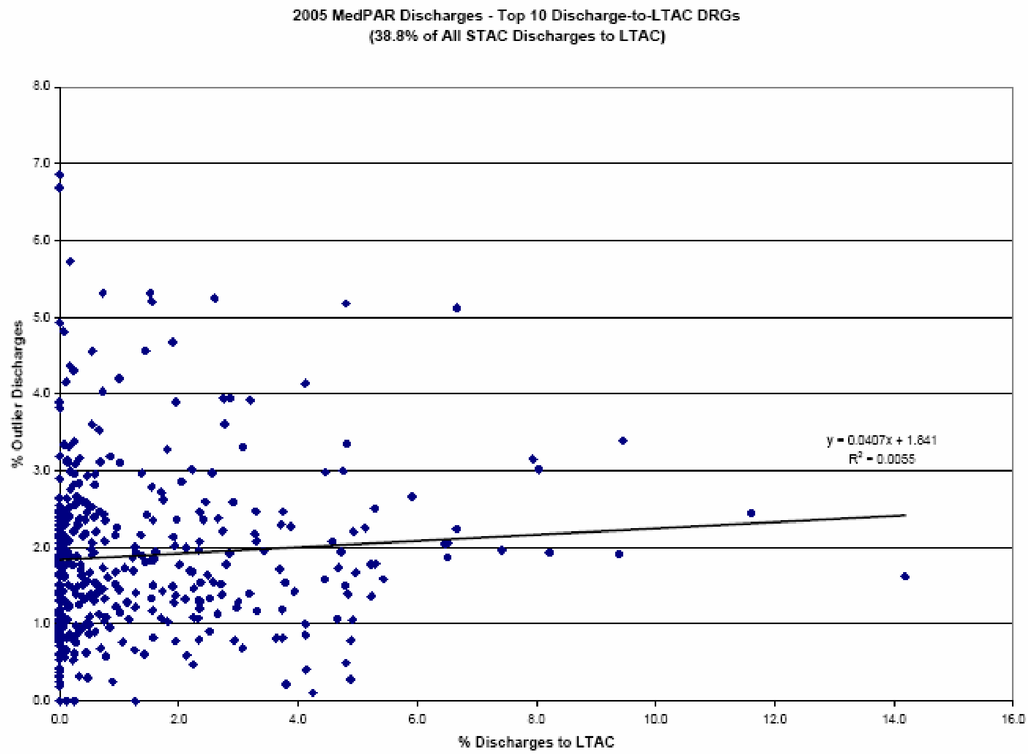


Figure 3

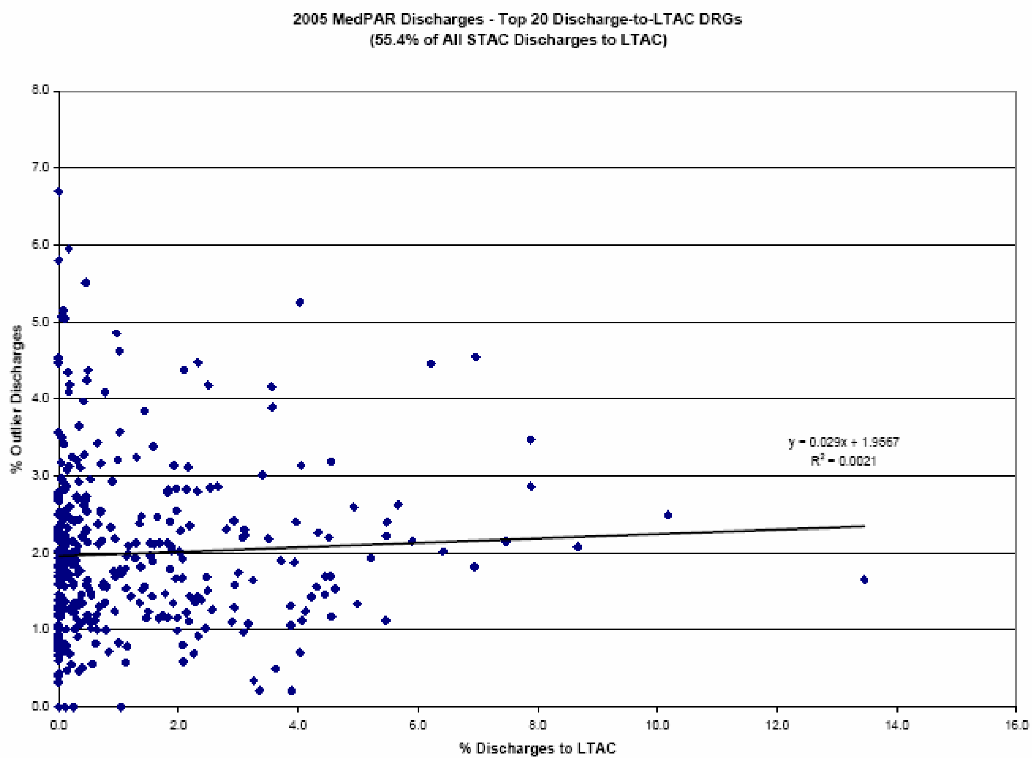


Figure 4

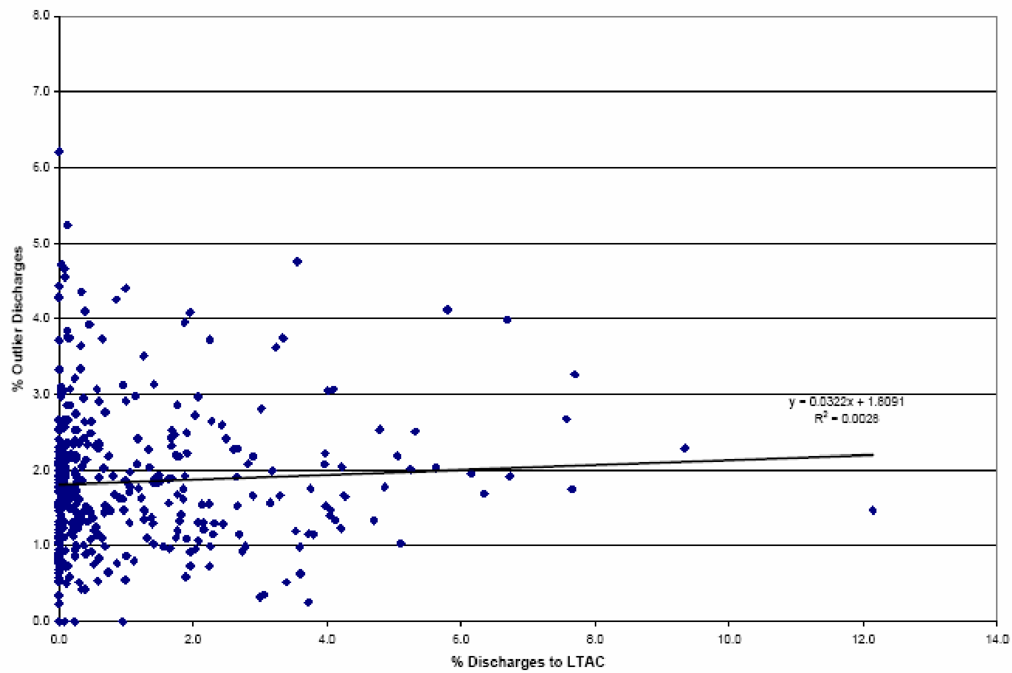
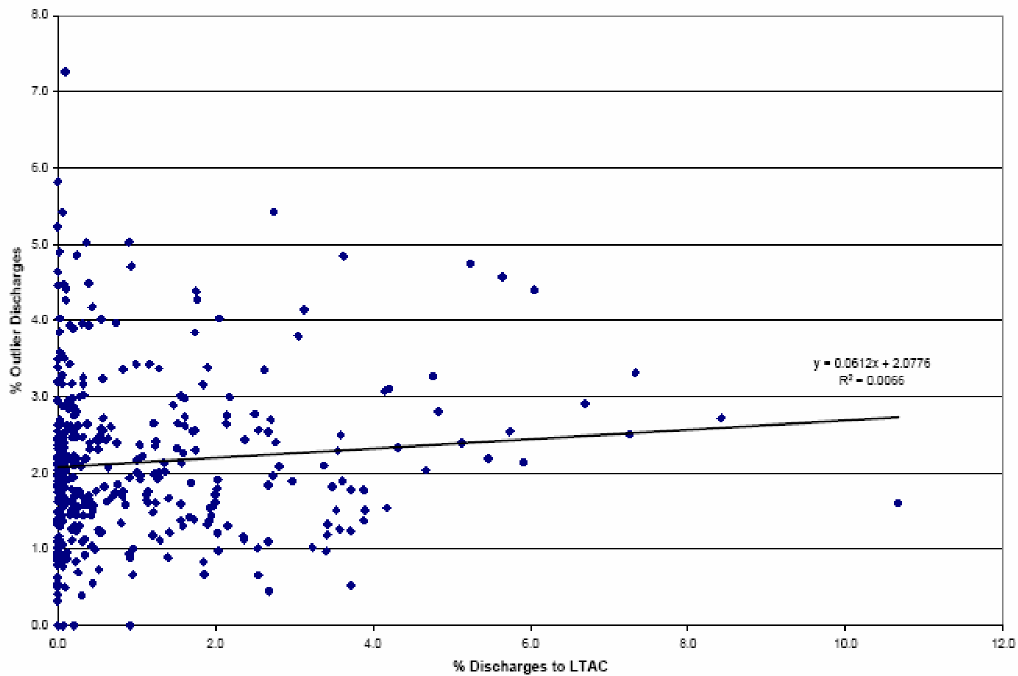
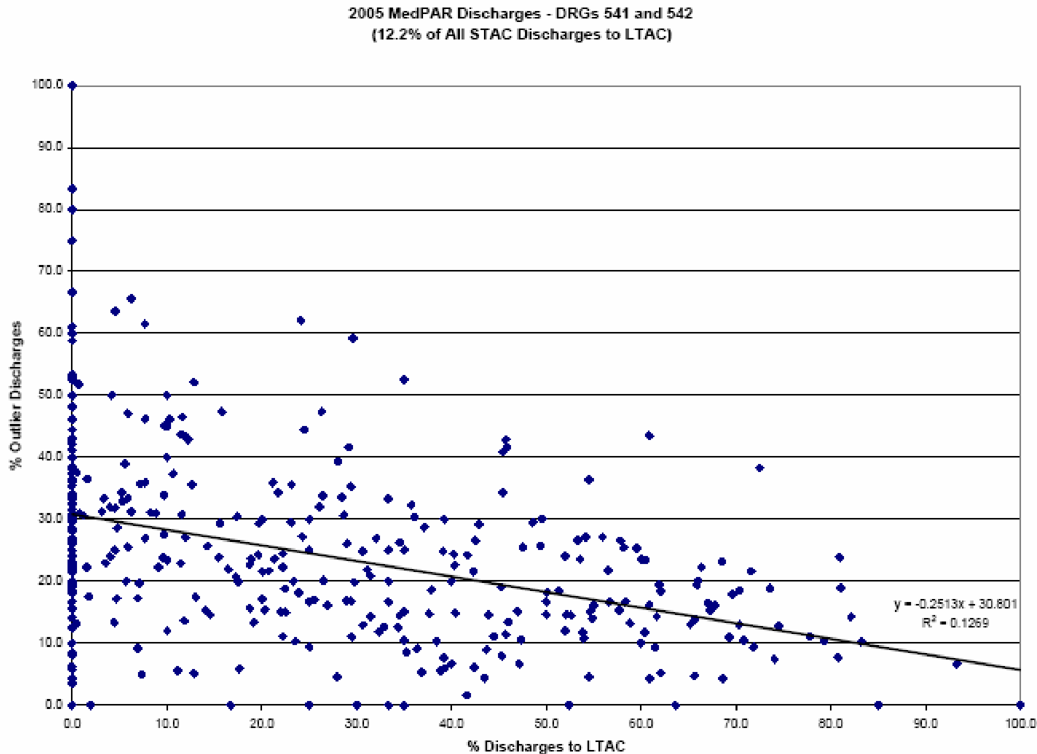


Figure 5



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

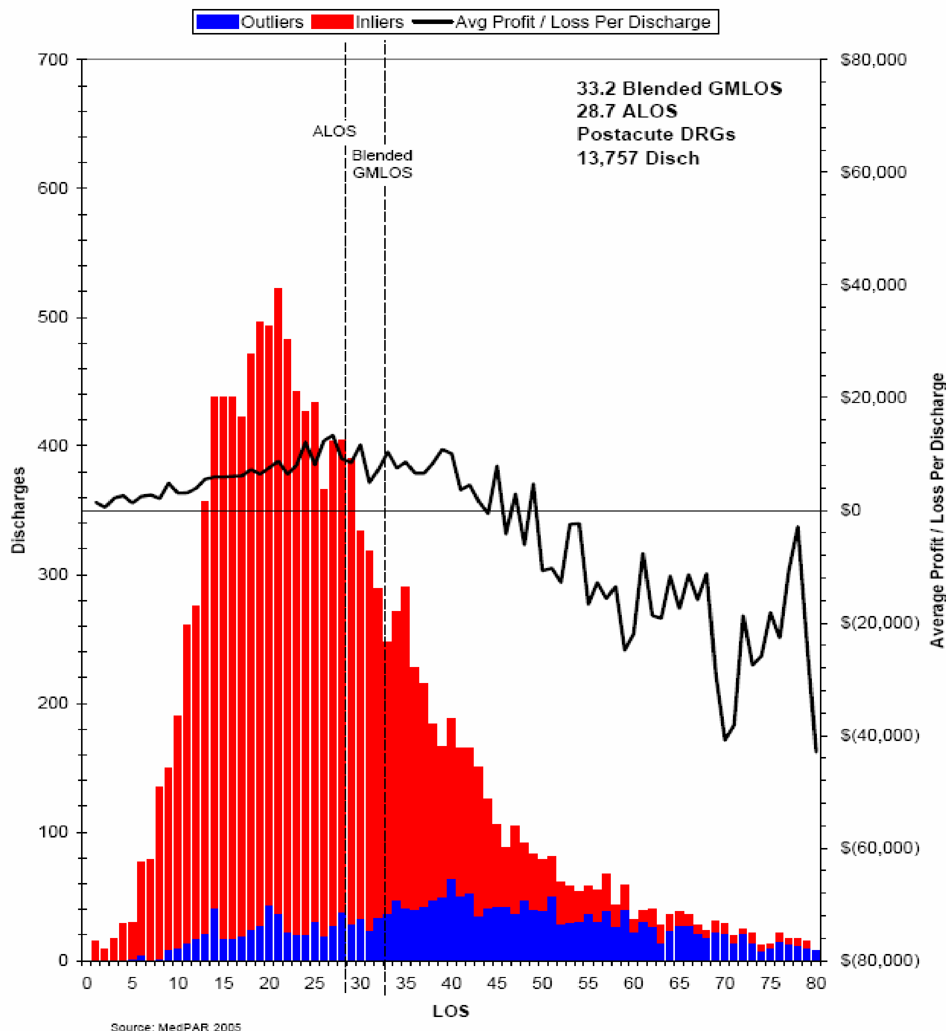


Despite the correlation indicated by the chart, this pattern does not support CMS's concern that LTACH utilization unduly increases costs to the Medicare program, for three reasons:

- 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.

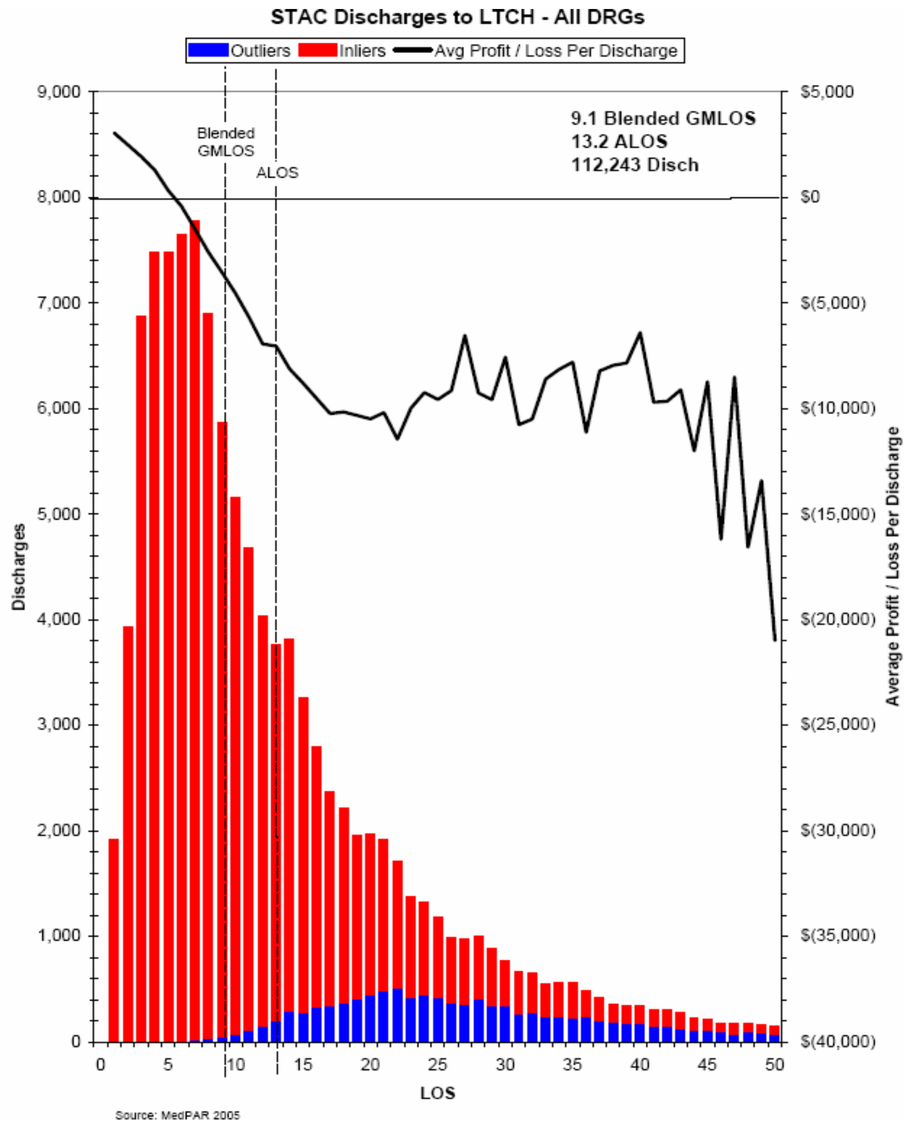
Figure 7



- 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.

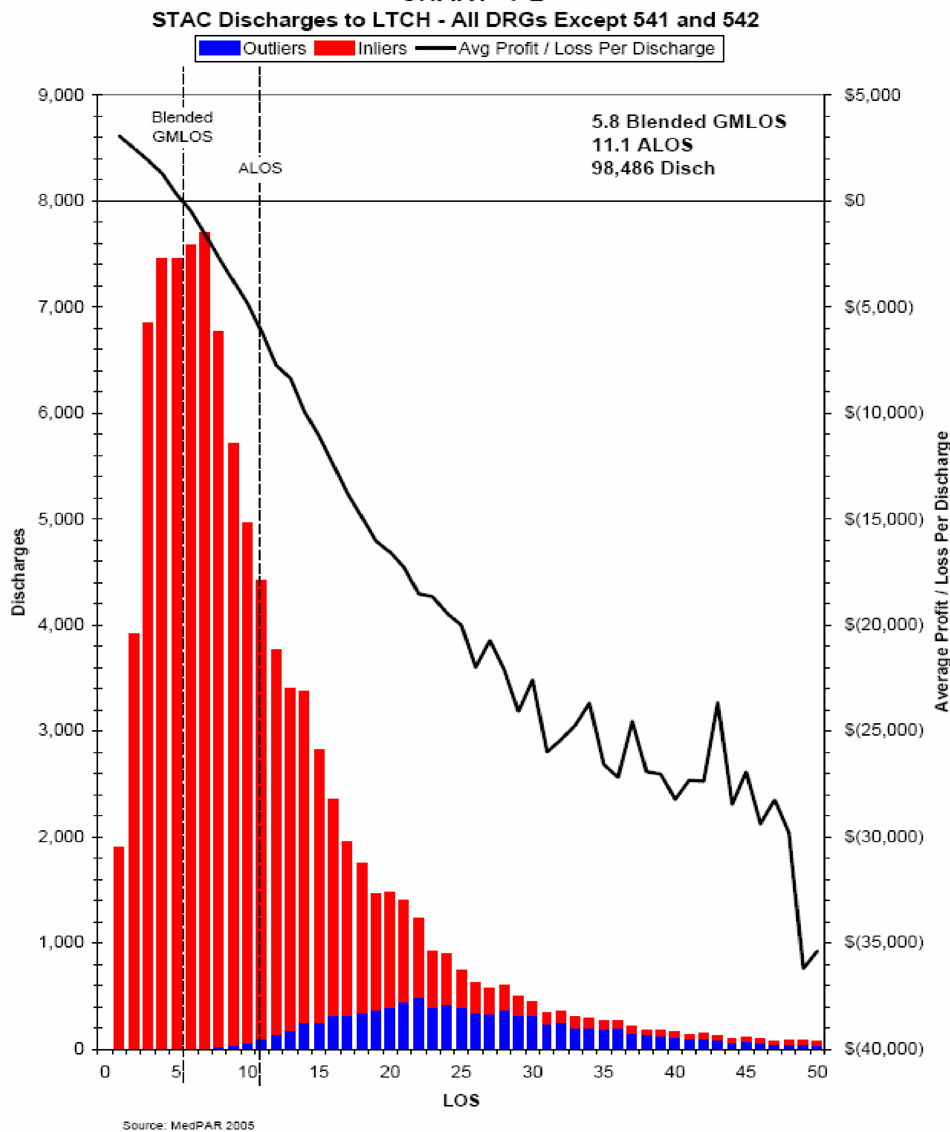
The graph in Figure 8 shows that the ALOS for acute hospital patients eventually sent to LTACHs is more than 4 days longer than the geometric mean length of stay for patients in the same DRGs.

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

LTACH Rank	DRG	DRG Description	LTACH PPS Discharges	IPPS Discharges	IPPS Discharge to LTACH Rank
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.

These policies are also 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. In addition to restricting access to care and discriminating against patients seeking services later in an LTACH's cost reporting year, the proposed rule will result in the lengthy continuation of care in STACHs or discharges to different types of post-acute care providers that are not equipped to provide the services or level of resources that are necessary to improve the condition of high-severity, medically complex patients. These are legitimate concerns that CMS cannot ignore by simply stating that this is a payment policy. If this were simply a payment policy, it would not establish patient quotas for the reasonable reimbursement at the LTACH PPS rates for only a small fraction of all LTACH discharges.

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

	STACH CASES:			LTACH SSO CASES:			All LTACH CASES:		
DRG	GMLOS	% in SOI 3,4	% in ROM 3, 4	ALOS	% in SOI 3, 4	% in ROM 3, 4	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.

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[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

DRG	STACH CASES: GMLOS	STACH CASES: % in SOI 3,4	STACH CASES: % in ROM 3, 4	LTACH VSSO CASES: ALOS	LTACH VSSO CASES: % in SOI 3, 4	LTACH VSSO CASES: % in ROM 3, 4	All LTACH CASES: GMLOS	All LTACH CASES: % in SOI 3, 4	All LTACH CASES: % 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%

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.

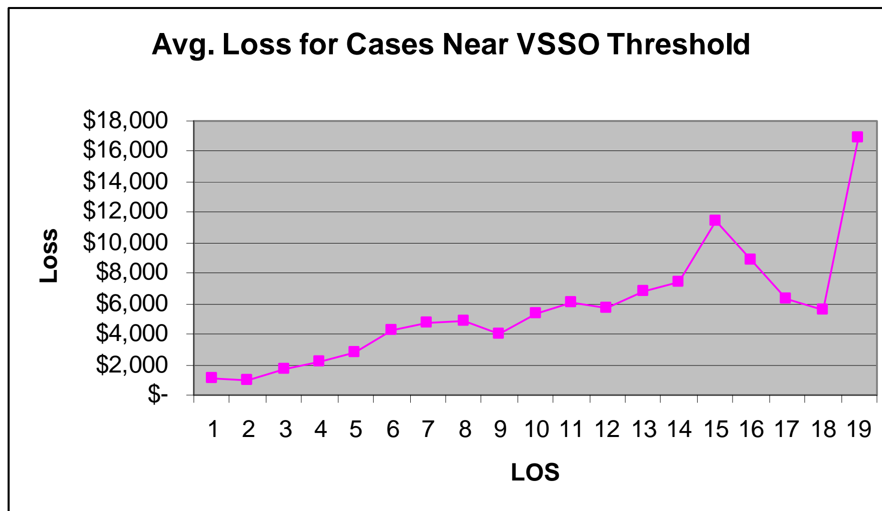
Superimposing STACH LOS distribution patterns, especially in instances where there are large standard deviations, on LTACH patients as a way of defining LTACH patients is not supported by data or common sense. Using the IPPS ALOS plus one standard deviation methodology to describe very-short-stay LTACH 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 5/6th 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 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.

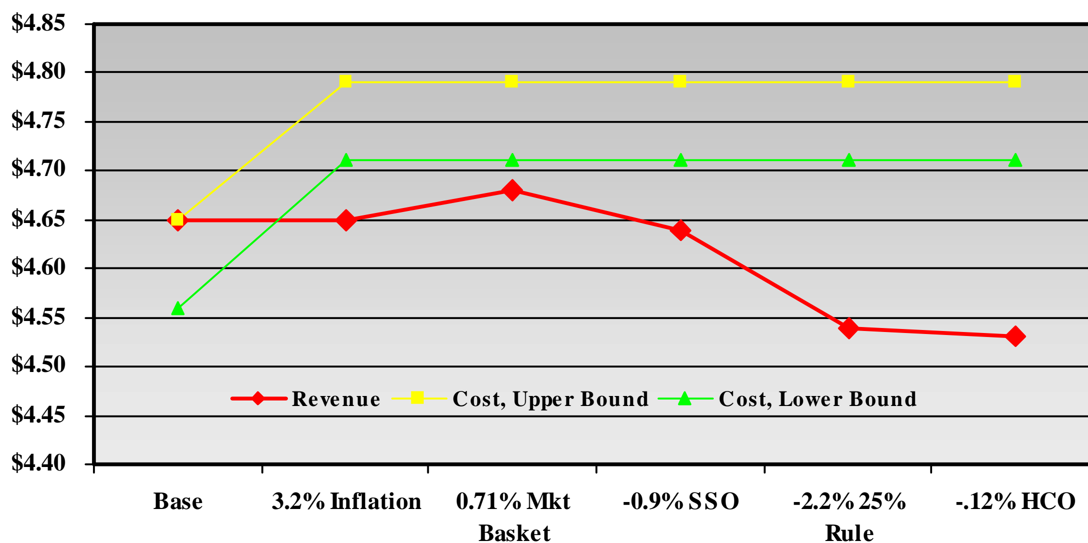
In the proposed rule, CMS states that under the proposed changes (*i.e.* VSSO payment reduction, reduced market basket update of 0.71%, and payments based on the inpatient PPS for admissions exceeding 25% from a single referral source) that payments will be adequate. However, detailed analysis of expected 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

RY 2008	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

Rate Year	Fixed-Loss Thresholds	Base Payment Amount
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

High Cost Outlier Data (2005 MedPAR)	
LTACH Cases	136,289
HCO Cases	12,883
Mean HCO Payment	$21,752
Impact of Proposal	
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

Plaza
Specialty Hospital

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: **Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates and Policy Changes [Docket No. CMS-1529-P]**

Dear Ms. Norwalk:

Plaza Specialty Hospital submits these comments on the proposed rule published on February 1, 2007. [72 Fed. Reg. 4776 et seq.] Plaza Specialty Hospital (PSH), a 65-bed LTCH Hospital within a Hospital (HwH), was established on January 1, 1995 and is located at 1300 Binz, Houston, TX.

In this rulemaking CMS is proposing to make significant changes to policies relating to admissions and payment for long term care hospitals (LTCHs). PSH is specifically concerned with the proposal to extend the 25% cap on admissions from any single referral source to the small number of HwHs (including PSH) to which the cap has not been applied pursuant to section 4417(a) of the Balanced Budget Act of 1997 (described in the preamble of the proposed rule as "subclause (I) grandfathered HwHs.") PSH believes the following factors provide ample justification for CMS to exclude the proposed expansion from the final rule.

I. <u>Expansion of the 25% rule to grandfathered HwHs would not achieve CMS' stated policy objectives.</u>

CMS justifies expansion of the 25% rule to all LTCHs, including grandfathered HwHs, based on the belief that these hospitals are operating as "step-down" units of acute care hospitals. In particular the agency is concerned with patient shifting between ACHs and LTCHs for financial rather than medical reasons. However, CMS has provided no clinical or financial evidence to support this presumption. To the contrary, CMS' own contractor investigating these issues, Research Triangle Institute, was unable to conclude that LTCHs are substituting for services already paid to IPPS hospitals.

Ironically, because CMS proposes that any discharge that has reached cost outlier status at the ACH would not count toward the calculation of the 25% threshold at the receiving LTCH, CMS' proposed policy itself would elevate financial considerations over the medical needs of the patient. As described in greater detail in the comments submitted by the National Association of

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Long Term Hospitals (NALTH), physicians at ACHs use their expertise and experience to discharge certain patients to LTCHs because of the specialized care they can receive at the LTCH. ACHs simply are not designed to provide for the long term inpatient care services needed by some patients. But under the proposed policy, LTCHs would be penalized for accepting transfers of patients until after they reached cost outlier status, regardless of whether the patient would benefit medically from an earlier transfer.

II. Congress Should Have the Opportunity to Complete Work on Legislation That Will Obviate the Need for the Proposed Expansion.

The LTCH industry and many Members of Congress believe that the 25% threshold is an arbitrary number that does little to limit LTCH admissions to those patients for whom treatment in a LTCH is medically necessary and appropriate. In fact, legislation has been introduced in Congress that would better achieve that objective through the development of specific clinical criteria governing LTCH admissions. [See S 338/HR 562.] Moving forward with the proposed expansion would threaten unnecessarily the continued operation of the small number of remaining grandfathered HwHs at the very time that Congress, CMS and the industry should be collaborating on these new requirements.

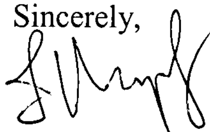
III. Expansion of the 25% threshold could result in the closure of the remaining grandfathered HwHs, which would limit beneficiary access to medical services and harm local communities.

Expansion of the 25% threshold to grandfathers HwHs would jeopardize the continued operation of PSH. (In our most recent cost reporting period, 58% of Medicare beneficiaries admitted to PSH were referred from our host hospital.) Closure of PSH and the elimination of its 65 beds would limit the availability of the unique services offered by LTCHs to Medicare beneficiaries in Houston. Moreover, CMS should consider the negative impact of closure of some or all of the grandfathered facilities on local communities. For example, PSH currently provides employment for 93 individuals in Houston and paid more than $32,164 in state and local taxes in 2006, benefits for the community that will be lost if CMS chooses to move forward with the proposed policy. In light of these potential impacts, it is hard to understand how the interests of either beneficiaries or the public would be served by implementing the proposal when congressional action is imminent.

In view of the fore-mentioned comments, Plaza Specialty Hospital respectfully requests that CMS not expand the 25% rule to grandfathered HwHs.

Thank you for your consideration of this most important matter.

Sincerely,



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March 23, 2007

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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."

Dear Administrator Norwalk:

The National Association of Long Term Hospitals ("NALTH") welcomes the opportunity to submit these comments on notice of proposed rulemaking ("NPRM") published on February 1, 2007 at 72 *Fed. Reg.* 4776 *et seq.* NALTH is committed to research, education and public policy development, which further the interests of the very ill (and, many times, debilitated) patient populations that receive services in long-term care hospitals ("LTCHs") throughout the nation and which promote understanding of the value added by, and commensurate resource needs of, LTCHs in the health care delivery system. NALTH's membership is composed of the nation's leading LTCHs, which serve approximately one-third of the Medicare beneficiaries who are admitted to LTCHs in the United States. The membership of NALTH is diverse. It includes not-for-profit and for-profit urban LTCHs with Medicare-approved teaching programs and over 200 beds, LTCHs located in underserved rural areas, LTCHs which are owned and operated by large integrated health care systems throughout the United States and publicly-owned LTCHs.

As an initial matter, NALTH agrees with, and supports adoption of, the proposed budget neutrality requirement for the annual long-term care diagnosis related group ("LTC-DRG") update. Also, NALTH understands that CMS intends to make a one-time adjustment to the LTCH prospective payment system ("LTCH-PPS") rates under 42 C.F.R. §412.523(d)(3), to be implemented on July 1, 2008. We ask CMS to confirm that, when making the one-time adjustment, it will consider and credit all non-budget neutral adjustments (such as to LTCH-DRG weights) which previously have been made. As for CMS' current proposals, NALTH <u>does</u> object to, and offers comments upon, the following components of the proposed rule:

- **the expansion of the so-called "25% rule" to apply to grandfathered hospitals-within-hospitals ("HwHs") and freestanding hospitals.**
- **the revision to the short-stay outlier ("SSO") policy under consideration that would reimburse approximately 31% of all SSO cases at payment levels "not to exceed the full [inpatient prospective payment system ("IPPS")] comparable amount";**
- **the increase in the high-cost outlier ("HCO") threshold amount from $14,887 to $18,774, which is related to the proposed SSO policy.**
- **NALTH requests a standstill on the phase-in of the current 25% rule which applies where an LTCH is co-located with another hospital;**
- **NALTH requests that CMS publish all changes to the elements of the LTCH-PPS in a single, annual LTCH-PPS rule-making, rather than its current method of publishing some elements in the LTCH-PPS update rule and others in the IPPS update rule.**

These comments are submitted by NALTH on its own behalf and on behalf of its members. NALTH has set forth specific recommendations on the proposed rule in Part VIII of these comments.

NALTH commissioned the Lewin Group to analyze both the policy justifications and the fiscal effects of key aspects of the proposed rule. The report, which NALTH has received from the Lewin Group, is entitled "Analysis of the Long Term Care Hospital RY 2008 Prospective Payment System Notice of Proposed Rulemaking" (March 23, 2007) and is included as Appendix A to these comments. In the following discussion, we refer to this report as the "Lewin Report."

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Preliminary Statement

Historically, it has been an accepted truism that a patient admitted to a short-stay acute care hospital subject to the IPPS (hereafter referred to as an "ACH") should not remain in that hospital setting longer than medically necessary and appropriate. When medically and clinically appropriate, the discharge of a patient from an ACH to an alternative setting, which a physician's judgment determines to be in the patient's best interests, is a desired outcome. Moreover, as an overriding fundamental matter, CMS has a duty in making policy decisions to "maximize net benefits" enjoyed by Medicare beneficiaries. *See* Executive Order 12866 (Sept. 30, 1993). The entire premise underlying the proposed changes to the short stay policy and the expansion of the 25% rule is to foster changes in physicians' and hospital administrators' behavior and to reduce beneficiary access to LTCHs. The underlying assumption – that patients staying in LTCHs for a

period less than the IPPS mean plus one standard deviation for the assigned DRG are "prematurely admitted" to an LTCH – must be questioned when measured against CMS' overriding responsibility to maximize Medicare beneficiaries' access to covered services. This responsibility also is difficult to reconcile with the asserted policy behind the 25% rule; *i.e.*, the fact that a patient did not reach cost-outlier status in the referral hospital plus the number of patient admissions to the LTCH from a single referral source (including a co-located hospital) somehow identify the patient as being discharged prematurely to the LTCH. We believe this policy, on its face, is inconsistent with CMS' responsibility to foster the maximization of Medicare beneficiaries' access to covered hospital services. This set of assumptions also conflicts with an incentive of the IPPS, which is to move patients out of ACHs as soon as possible. This dynamic, which created the current post-acute care industry, cannot easily be thwarted by regulatory changes such as those proposed. Physicians have the responsibility for patient advocacy, not the CMS rule-making process.

In light of this, the Secretary has endorsed the following principles. First, in connection with the initial IPPS rule-making, the Secretary rejected claims that the IPPS would reduce quality of care if patients were to be discharged sooner from ACHs based on a physician's judgment:

> First, the physician, not the hospital administrator, makes the decision to admit and discharge patients and order procedures. . . . Perhaps most important, the physician's professional and ethical standards protect the patient from the withholding of needed care. And, in a DRG payment system not covering all payors, the physician would still be likely to engage in a uniform style of practice for all patients.
>
> ***
>
> Third, we expect that the hospital's efforts to reduce costs, particularly by reducing the length-of-stay, will not necessarily affect quality of care. Considered in itself, a hospital's attempts to reduce average length-of-stay could have either positive or negative effects on patients' health. On the one hand, hospitalization itself carries certain risks, such as those of nosocomial infections and iatrogenic illness; shorter lengths-of-stay reduce this risk. Psychological factors associated with hospitalization may also be important in adversely affecting outcomes. Further, we believe that effective discharge planning affords hospitals an opportunity to reduce the length of stay, without adversely affecting quality. On the other hand, we grant, and Congress recognized, that too early discharge could place patients at risk of inadequate care and threaten recovery, and we have therefore implemented a monitoring system designed to review the appropriateness of admissions and discharges.
>
> 49 *Fed. Reg.* at 308 (January 3, 1984).

In discussing the transfer policy to be implemented in connection with the IPPS, the Secretary again underscored the primary role of the physician:

> Finally, we do not believe that the transfer policy contained in the interim final rule will affect the quality of care furnished to Medicare inpatients. The decision on whether to transfer a patient will ultimately be made on the basis of medical considerations, with the welfare of the patient being the primary consideration. In any event, as indicated above, we do not believe that our transfer policy is either disadvantageous to the transferring hospital or results in any danger of declining quality of care.
>
> 49 *Fed. Reg.* at 245 (January 3, 1984).

In connection with the transfer policy as it concerned transfers from an ACH to a hospital excluded from the IPPS, such as an LTCH, the Secretary underscored the following:

> . . . As we stated in the interim final rule, we believe that hospitals and units excluded from the prospective payment system are organized for treatment of conditions distinctly unlike treatment encountered in short-term acute care facilities. Therefore, the services obtained in excluded facilities would not be the same services obtained in transferring hospitals (that is, paid under the prospective payment system), and payment to both facilities would be appropriate, with the transferring hospital paid at the full DRG prospective payment rate.
>
> Thus, the significant factor in determining the payment to a transferring hospital is the type of hospital to which the patient is transferred. . . . Similarly, full DRG prospective payment should be made to a transferring hospital where the patient is transferred to a hospital that would be excluded from the prospective payment system, regardless of that hospital's location or its cost reporting period. . . .
>
> 49 *Fed. Reg.* at 244 (January 3, 1984).

From a big picture point of view, the Secretary's proposed rule (particularly the 25% rule and its expansion) represents a repudiation of the various rationales that the Secretary put forward to justify the then new IPPS and the transfer policies accompanying that new payment system. First, the Secretary's proposed rule eliminates the role of the physician in the patient admission and discharge processes. Indeed, the Secretary's prior insistence that "medical considerations" determined by a physician's exercise of medical judgment must control admissions and discharges is now dismissed outright by the Secretary. By dictating a *per se* rule that wrongly but conclusively presumes that a patient belongs in an ACH until the patient, under physician care, achieves IPPS cost-outlier status, the Secretary has, as a practical matter, reduced the role of physician decision-making and the exercise of medical judgment to a nullity. Nowhere in the proposed rule is there any medical or clinical evidence that a patient must remain in an ACH until outlier status is reached. While the preamble to the proposed rule repeatedly

states the objectives of the 25% rule and proposed SSO policies are to prevent premature discharges to LTCHs, nowhere is the primary role of physician and patient decision-making discussed or even acknowledged. Indeed, as discussed below, LTCHs achieve success with transferred patients when the transfer occurs earlier, not later.

Second, the Secretary's proposed rule (and again, particularly, the 25% rule and its expansion) is contrary to an objective stated by the Secretary in enacting IPPS rules -- namely, to reduce ACHs' average lengths of stay ("ALOS"). Without a shred of medical or clinical evidence, the Secretary has made a further incorrect, conclusive presumption that a patient in an ACH experiences a single spell of illness until the patient achieves IPPS outlier status. Here again, the Secretary is repudiating previous pronouncements that spell of illness determinations, which, at their, core represent physicians' exercise of medical judgment, must be decided by physicians. Here again, the proposed rule conflicts with physician judgment and relegates physician judgment to non-factor status.

Third, in connection with LTCHs, the Secretary's proposed rule (and again, particularly, the 25% rule and its expansion) both ignores and is contrary to the Secretary's prior pronouncements that ACHs and LTCHs are not organized to treat identical conditions and, in fact, do not treat identical conditions. The Secretary's insistence on using catch phrases in the preamble to the proposed rule such as "one spell of illness" and "single episode of care," does not derogate from the Secretary's previously-stated conclusions that patients in ACHs and patients in LTCHs receive (and are entitled to receive, when directed by a physician) different resources. LTCHs serves critically ill, medically unstable patients who are not progressing or who, for example, have failed to be weaned from a ventilator and require the multidisciplinary program of long-term care in which LTCHs specialize.

I. Summary of Adverse Overall Financial Impact of Proposed Update Rule.

Lewin calculated margins for LTCHs based upon reimbursements reflecting the 2008 NPRM policies, included the updates to the Federal standard rate and wage index, as well as the proposed changes to the SSO and 25% rule policies. The most recent Medicare cost report for each LTCH was used to calculate costs. According to the Lewin analysis, LTCHs will experience a decline in average payments of approximately 4.0%. Lewin Report, p. 2. This significant reduction in reimbursement, coupled with increasing costs of providing health care, leads towards the estimated -4.3% margin for the LTCH industry based on the proposed 2008 payment policies. For cases subject to the 25% rule, hospital margins would be negative -39.6%. Lewin Report, p. 24. For cases paid under the proposed very SSO rule, hospital margins would be a negative -17.8%. Lewin Report, p. 21. The Lewin Groups estimates that nearly 60% of LTCHs will have negative margins (*i.e.*, margins below zero). Lewin Report, p. 9. In contrast, the overall RY 2007 margin was estimated to be 2.9%. The RY 2008 estimated margin, including the SSO proposed changes but excluding the impact of the 25% rule, is -0.84%. Lewin Report, p. 3. This estimate also is well below the 4-6% positive margin generally thought to be required to support hospital modernization and refurbishment and to allow the hospital to keep current with emerging technologies. The final margin estimates, including the impact of the SSO and 25% rule RY 2008 proposed policies are displayed in **Exhibit 1**, by types of LTCHs and overall.

Exhibit 1. Simulated RY 2008 LTCH-PPS Margins, Percent Negative Margins and Margin Percentiles by Hospital.

LTCH Classification		Number of LTCHs	Number of LTCH Cases	RY2008				
				Average margin	Percent Negative	Percentile		
						25th	50th	75th
All Providers		369	130,599	-4.31%	59.51%	-18.65%	-6.24%	2.96%
By Location								
	Large Urban	181	78,026	-1.8	50.8	-12.4	-3.9	6.7
	Other Urban	163	47,307	-8.2	66.3	-22.1	-10.4	0.2
	Rural	25	5,266	-11.5	79.2	-24.8	-13.0	-2.3
By Ownership / Control								
	Voluntary	122	38,806	-7.2	65.6	-23.8	-10.2	0.3
	Proprietary	232	86,387	-2.9	56.3	-16.3	-4.2	3.8
	Government	15	5,406	-7.6	60.0	-41.9	-12.1	12.4
By Region								
	Midwest	84	24,073	0.5	46.4	-16.5	-3.4	6.7
	Northeast	42	17,810	0.3	41.5	-10.9	-0.1	8.1
	South	205	73,823	-9.2	71.2	-24.8	-10.9	-1.7
	West	38	14,893	2.3	44.7	-6.2	-1.2	7.5
By Bed Size								
	1: 1-24	41	7,683	-8.64	75.61	-31.79	-14.42	-2.40
	2: 25-49	197	51,891	-6.09	54.59	-18.99	-7.33	2.96
	3: 50-74	57	23,132	-4.64	68.42	-14.01	-5.05	2.05
	4: 75-124	42	23,800	-2.62	61.90	-12.11	-5.13	6.92
	5: 125-199	18	12,379	-2.33	61.11	-13.03	-7.76	9.54
	6: 200 - 299	10	7,799	-2.44	50.00	-18.44	-0.13	13.11
	7: 300+	4	3,915	8.40	0.00	5.10	10.59	28.43

According to the margin estimates, the proposed changes to the SSO and 25% rule policies have an inequitable, detrimental impact on margins for other urban and rural LTCHs. This may be reflective of the market area differences between areas with more hospitals (*i.e.*, urban hospitals) versus those with fewer hospitals (*i.e.*, other urban and rural hospitals). The areas with fewer hospitals may be forced to take on a greater percentage of cases from a single source and, unavoidably, have many of their cases impacted by the 25% rule. This is an indication that the current exceptions allowing higher threshold amounts for hospitals in single urban and MSA-dominant areas are not providing enough protection for these hospitals.

Not surprisingly, a very high correlation between hospital bed size and margins was found after the inclusion of the 25% rule in Lewin's calculation of the proposed rule's impact. Medicare margins are over 8% for the four LTCHs with more than 300 beds and negative for LTCHs with less than 300 beds, with the margins getting lower as the bed size decreases. This effect may be related to the geographic area phenomenon.

The LTCH-PPS as proposed in the FY 2008 NPRM:

> is a system of exceptions not a system of averages. Before accounting for the 25 percent policy, 53 percent of cases are regular LTC PPS cases, 36 percent are short stay cases, and 11 percent are HCO cases under the FY2008 NPRM. Including the 25 percent policy expansion these figures are 50 percent, 34 percent, and 10 percent respectively with 6 percent being paid under the aggregate 25 percent policy. Our margin calculations excluding the 25 percent policy show LTCHs losing -0.84 percent and -4.31 percent including the 25 percent policy.

Lewin Report, p. 37.

II. Proposed Expansion of the "25% Rule."

NALTH **strongly objects** to the proposal to expand the current 25% rule to freestanding hospitals and to those hospitals which have been grandfathered by Congress from the HwH and satellite rules by Section 4417(a) of the Balanced Budget Act of 1997. NALTH also requests that CMS initiate a standstill of the ongoing phase-in of the current 25% rule, for LTCHs which are co-located with another hospital. NALTH's objections are based on empirical, policy and legal grounds. As detailed below, NALTH believes that the proposed expansion of the 25% rule (as well as the continued phase-in of the current rule) profoundly distorts the LTCH-PPS and violates important primary directives of the Social Security Act.

One of the key findings in the Lewin Report is that cases subject to the 25% rule have an ALOS of 25.7 days. Lewin Report, p. 27. This is precisely the patient ALOS which Congress has mandated defines an LTCH under Section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. §1395ww(d)(1)(B)(iv)). The Secretary cannot rightly (*i.e.*, legally) pay for cases which meet the 25-day ALOS LTCH certificate requirement on a short-term IPPS basis.

Lewin also found that cases subject to the 25% rule would be paid, on average, only $401.40 per day (*see* Lewin Report at pp. 24 and 27 and p. 16, *infra*.)

The policy premise offered by CMS in support of the 25% rule is based on the assumption that LTCHs admit many patients "prematurely" from ACHs and that these admissions plus the care that was provided at the ACH constitute a "single episode of care." The preamble to the proposed rule offers no evidence that this is the case and does not justify the 25% rule on any empirical grounds. Indeed, CMS' contractor RTI, which is charged with studying this issue, recently has reported 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 (February 1, 2007). Our comments here include evidence that patients who would become subject to the 25% rule are different from patients in short-term ACHs and, therefore, there is no empirical basis whatsoever to support CMS' assumption that LTCHs systematically engage in substitution of service. The litmus test for admission to any class of Medicare provider cannot rightly be how expensive a patient's care was in another setting or how many patients previously were admitted to an LTCH from another hospital. These two standards form the pillars of the 25% rule and cannot rightly

substitute for a clinical, physician-driven determination of the individual patient's care requirements. In Part VIII of these comments, NALTH offers recommendations as to alternative policies which are patient-centered and provide a reasonable alternative mechanism to CMS' substitution of service concerns.

We wish to register a special concern that the Secretary has not developed, let alone implemented, LTCH facility-specific and patient-specific criteria consistent with the process recommended by MedPAC in its June 2004 Report to Congress. These recommendations were well known among health care policymakers before MedPAC made its 2004 Report to Congress and now have been pending before CMS for almost three years. In its March, 2007 Report to Congress, MedPAC again registered its strong concern that CMS has not developed these criteria and instead has defaulted to the policies embodied in the 25% rule. MedPAC referred to the 25% rule as "arbitrary" and as "increas[ing] the risk for unintended consequences." MedPAC, accordingly, "urgently" suggested that CMS implement criteria in lieu of the 25% rule "as soon as possible." *See* MedPAC, March, 2007 Report to Congress on Medicare Payment Policy, p.226. NALTH, therefore, believes that good cause now exists for CMS to reassess its policy and consider an alternative approach to address its concerns. If CMS does not agree with our recommendations, we believe it is important for CMS to adopt a regulatory standstill under which there would be no expansion of the 25% rule to freestandings and grandfathered HwHs and under which the phase-in of the current 25% would remain at its current, FY 2007 levels for the various classes of HwHs identified in 42 C.F.R. §412.534. We note that CMS is suggesting changes to the 25% rule before any data are available to determine the impact of the existing 25% rule. This seems precipitous at best, considering that unintended consequences could be severe.

A. Background.

Under current 42 C.F.R. §412.534, if an LTCH HwH or LTCH satellite has more than 25% of its Medicare discharges during a cost-reporting period admitted from its co-located hospital (prior to reaching outlier status at the host hospital), then the LTCH HwH's or LTCH satellite's payments for those patients <u>exceeding</u> the 25% threshold are the lesser of:

i. the amount otherwise payable under LTCH-PPS; or
ii. an amount "equivalent to" what would be paid under IPPS.

The current rule allows for a phase-in, with the 25% threshold becoming effective (for most HwHs and satellites) for cost-reporting periods beginning on or after October 1, 2007. Earlier years have higher thresholds. The current rule also has special treatment for rural LTCH HwHs and satellites (which have a 50% threshold), and urban single or MSA-dominant HwHs and satellites (which have a threshold calculated specifically for them, in the 25% to 50% range).

In the RY 2008 Proposed LTCH-PPS Update Rule, CMS has proposed expanding the 25% rule to apply to <u>**ALL**</u> LTCHs, including grandfathered co-located LTCHs and freestanding LTCHs. CMS proposes expanding the 25% rule in 2 parts:

1. **42 C.F.R. §412.534.** This section, discussed prior hereto, would be revised to extend the 25% (or other, applicable percentage) to grandfathered hospitals (those co-located LTCH HwHs and satellites which are grandfathered – under 42 C.F.R. §412.22(f) – from the strictures on common control located at 42 C.F.R. §412.22(e)). The current rule does not apply to grandfathered hospitals.

2. **42 C.F.R. §412.536.** In this proposed section, CMS would apply the existing 25% (or applicable percentage) adjustment to any LTCH or LTCH satellite (except one which qualifies as an LTCH under §1886(d)(1)(B)(iv)(II) of the SSA), "regardless of the physical proximity to the hospital from which it is accepting admissions." In other words, if adopted, 42 C.F.R. §412.536 would apply to freestanding LTCHs, LTCH HwHs (including grandfathered HwHs) and LTCH satellites. If such a hospital admitted more than 25% (excluding outliers) of its Medicare discharges during a cost-reporting period from any one hospital (whether co-located or not), payment for patients who caused the facility to exceed the 25% (or applicable percentage) threshold would be paid at IPPS-equivalent rates.

A co-located LTCH HwH or satellite would be subject to both 42 C.F.R. §412.534 (in relation to admissions from its co-located host) and 42 C.F.R. §412.536 (in relation to admissions from any other hospital).

B. The 25% Rule is *Per Se* Administratively Unworkable and Unfair.

NALTH members who are subject to current phase-in of the 25% rule have experience with attempting to manage a hospital while taking into account the requirements and incentives contained in the rule. They report that they generally do not know the DRG of a patient upon admission and also are not able to identify whether a Medicare patient was an HCO at the time of admission from an ACH. *See* Lewin Report, p. 23 . This information is typically not available to LTCHs and may not exist in a referring ACH at the time a patient is admitted to an LTCH. "Because it is difficult to identify these ACH HCOs at the time of LTCH admission, LTCHs may believe they are reaching the 25 percent rule prematurely. This is problematic as it could lead to an increased number of patients being denied care **unnecessarily**." Lewin Report, p. 23 (emphasis added). LTCHs clearly do not know and cannot know the DRG assignment of a case whose DRG subsequently is changed as a result of DRG validation efforts by Quality Improvement Organizations ("QIOs"). LTCHs also do not know when the number of admissions they receive from a single referral source are approaching the applicable percentage referral threshold which triggers payment under the 25% rule. This data only will be available to fiscal intermediaries after MedPAR data becomes available, several years after the patient is discharged from an LTCH.

The 25% rule, in a very real sense, would convert the LTCH-PPS into a retroactive system of recovery and settlement with related disputes where CMS would be called upon to produce patient records from hospitals that refer cases to LTCHs as well as individual patient coding and referral hospital financial information to support recovery claims. NALTH members

report that it is very difficult to provide for this type of contingency in accordance with generally accepted accounting principles.

The 25% rule provides an incentive for LTCHs to assume most patient admissions count toward the 25% rule and that LTCH administrators will influence physician decisions as to where and when to admit a patient. Where other LTCHs exist in a service area, the incentive exists to deny admission and shift patients to other LTCHs in the area. The rule clearly operates to intrude on physician and patient selection of the appropriate placement of care and will not necessarily accomplish CMS' purpose where patient shifting occurs. Thus, the rule is administratively unfeasible. It is unworkable from a hospital's perspective, cumbersome or perhaps infeasible for the Medicare program to administer and, most importantly, will operate to delay or deny patients access to care. The rule also makes financial planning for LTCHs all but impossible, since LTCHs will not be able to predict their Medicare payments with any accuracy. This would violate a fundamental rule of perspective payment systems that payments will be prospectively set and known in advance by the providers.

C. The Policy Predicate to the 25% Proposal, that LTCH Cases which Failed to Reach Outlier Status at the Referring ACH Are Inappropriate Transfers to LTCHs, Is Not Stated in Careful Clinical Terms and Is Factually Wrong and Logically Flawed.

With the assistance of the Lewin Group, NALTH has reviewed closely the reasons and rationales proffered by CMS for this proposed change in Medicare payment policy. CMS' articulated policy basis for the 25% rule is that Medicare beneficiaries who are discharged to LTCHs are "presumably prematurely discharged" if they have not previously reached cost-outlier status in the discharging hospital. *See* 72 *Fed. Reg.* 4811 (Feb. 1, 2007). CMS intends that the 25% rule will control physician and hospital behavior in providing and denying Medicare beneficiaries access to care in LTCHs.

There is absolutely no clinical support for CMS' assumption that an admission made prior to the patient's reaching cost-outlier status at an ACH is inappropriate or premature. A policy that will cause serious adverse financial harm to hospitals, as well as have negative medical care implications for Medicare beneficiaries, should be based on more than beliefs and clinical speculation by CMS. There simply is a lack of data to support CMS' taking of such drastic action. As noted in the Executive Summary of RTI's Report, "[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. In short, even the expert hired by CMS to look into the appropriateness of LTCH admissions does not have evidence conclusively showing that the typical LTCH patient could be treated in an ACH. Moreover, even if there were clinical data to support CMS on this point, CMS should not address the issue with an irrebuttable, presumptive statistical rule that fails to examine the clinical or financial aspects of the cases involved.

In Part II. J. of these comments, NALTH also has presented its views that the engineering of patient access and admission to a hospital, including an LTCH, through mechanisms in a payment system, violates federal law.

The Lewin Group conducted structured interviews with physicians from both ACHs and LTCHs regarding how the 25% rule would affect their patients and practices. The physicians indicated that it is clinically important that patient access to LTCH services not be delayed, and that, while care in ACHs is diagnosis-based, LTCHs provide specialized programs of "whole patient recovery" for patients who require an entire multidisciplinary team. It is clear that, for example, the denial or delay of the admission to an LTCH of a patient who has failed multiple weaning attempts in an ACH can be expected to decrease the probability that the patient will be weaned successfully. The policy objective of the 25% rule, which is to provide an incentive for LTCHs to avoid the admission of patients who are not IPPS cost-outliers, is clearly a policy which fosters delay in obtaining care in an LTCH and raises serious patient access and care questions.

> Physicians interviewed concerning the incentives of the 25% rule reported that: "If patients are transferred from the ACH 'too late,' they are in worse condition with multiple comorbidities that could have been avoided or have been less serious if the LTCH could have received the patient earlier. If ACHs keep patients long enough to get the full PPS-DRG payment, or a PPS outlier payment, but do not provide any whole patient care while the patient is in the ACH, clinical problems can emerge. For instance infections, ulcers, nutrition, and atrophy of muscles can worsen if ACHs hold patients too long. In the end Medicare may pay more in outlier payments to the ACH than if the patient is transferred to an LTCH in a timely fashion." Lewin Report, p. 12.
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> One physician's observation to the incentives of the 25% rule made the point clearly that: "The sooner a patient can be admitted to the LTCH, the potential for recovery is increased. The focus is on the whole patient and not the disease specific focus, which is necessary in the ACH." Lewin Report, p. 15.

LTCHs provide a specialized hospital service based on a team approach. Patients with multiple organ failure often can recover, if they are admitted to LTCH care on a timely basis, sooner rather than later. CMS should strive for best clinical practices. CMS' LTCH payment policies do not encourage best clinical practices. That is, CMS needs to replace questionable payment policy judgment with sound clinical judgment.

In responding to this comment, it is important that CMS give due consideration to its overriding obligation to formulate public policies which operate in the best interest of beneficiaries and give primary weight to the primacy of physician decision-making and the maximization of beneficiary benefits, in accordance with the standards set forth in the preliminary statement to these comments.

We also note that the impact of the 25% rule, to delay patient access to LTCHs, predictably has the effect of causing beneficiaries to unnecessarily use their limited Medicare day benefit, including lifetime reserve days. In some cases, Part A benefit days predictably will become exhausted, requiring Medicare beneficiaries unnecessarily to spend-down their personal assets.

D. LTCH Cases Represent a Different Clinical Population Than ACH Patients and Use More Intensive Medical Resources. Therefore, the 25% Proposal Will Harm Medicare Beneficiaries.

As noted below in this Part II. D. of these comments, resource use by patients in ACHs and LTCHs is different and it was because of this difference that Congress mandated the establishment of the LTCH-PPS. *See* Section 4422 of the Balanced Budget Act of 1997 (P.L. 105-33) and Section 123 of the Balanced Budget Refinement Act of 1999 (P.L. 106-113). The marked difference between the standard payment amounts under the IPPS and the LTCH-PPS is an empirically-based acknowledgement by CMS of the different resources used under each system. Therefore, paying LTCHs under IPPS payment parameters is highly inappropriate from both clinical and payment perspectives, especially since CMS can point to no information whatsoever to support their claim that, if more than 25% of admissions come from one hospital, the patients are not receiving their full course of care in the discharging ACHs.

CMS asserts, without any clinical evidence, that ACH discharges to LTCHs of patients who have not yet reached outlier status at the ACH are "premature" discharges. This assumption fails to consider the fact that the care received by patients at LTCHs often is unique and not available at an ACH. The physician at the ACH decides to discharge a patient to an LTCH based upon the best interests of the patient and the particular services that can be found at the LTCH.

The policy objective underlying the proposed expansion of the 25% rule is to preclude LTCHs and physicians, through the imposition of a severe financial penalty, from admitting more than 25% of their patients (excluding those who have reached outlier status) from any one hospital. CMS is making the unilateral and unfounded medical decision that these patients should not be admitted to LTCHs. The assumption underlying this admission initiative – that patients who have not yet reached outlier status at an ACH are not appropriate cases to be admitted to LTCHs – is unsupported and untrue. There is a broad range of Medicare beneficiary patients who would not improve in the absence of receiving care in an LTCH. When MedPAC submitted its June 2004 Report to Congress, it stated its significant finding that patients treated in LTCHs have a 26% less frequent readmission rate to ACHs than similar patients who are not treated in LTCHs.[1] In order to be readmitted to an ACH, a patient's condition must deteriorate and the patient must be medically unstable. Under the proposed 25% rule, patients who require the specialized resources in an LTCH would be placed in harm's way when care in an LTCH is delayed or denied.

The Lewin Group performed an empirical inquiry to test CMS' assumption that patients admitted to LTCHs prior to becoming cost-outliers in ACHs are prematurely discharged and should have remained in an ACH. To do so, the Lewin Group used a patient-identifiable 2005 MedPAR dataset. This dataset allowed Lewin to track a Medicare beneficiary through all of his or her Medicare inpatient hospital stays resulting in discharges during 2005. Therefore, the Lewin Group was able to identify discharges from other hospitals (included ACHs, inpatient rehabilitation facilities and psychiatric hospitals) that occurred on the same day as admissions to LTCHs. These same day discharge/admission transactions were identified as transfers from a

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[1] *See* MedPAC's June 2004 Report to Congress, Chapter 5 ("Defining Long-Term Care Hospitals") at p. 127.

non-LTCH hospital to an LTCH hospital, which would be eligible to be counted towards the applicable 25% threshold.

After the eligible cases were identified and sorted based on admission date, the Lewin Group counted the cases eligible for the applicable 25% threshold, based on the admission date. These counts were on a discharging hospital/admitting LTCH basis. Thus, it is possible that a single LTCH could reach the applicable threshold with multiple hospitals. In order to determine if the applicable threshold is reached, the Lewin Group used the formula below:

$Cases_{hlc}/Cases_{l} > Threshold_{l}$ where:

$Cases_{hlc}$ = the cumulative count of eligible cases through case *c* from discharging hospital, *h,* and LTCH, *l*
$Cases_{l}$ = the total number of admissions for LTCH, *l*, and
$Threshold_{l}$ = the applicable threshold for the discharging/admitting LTCH combination, *l*.

Thus, once the first case for any discharging hospital/admitting LTCH combination is associated with a proportion greater than the applicable threshold, all succeeding eligible cases (based on admission dates) for that combination also will fall under the 25% rule. Implicit in the 25% policy is the fact that, after a certain arbitrary date,[2] all cases from that discharging ACH will receive a reduced payment, regardless of the severity, cost or appropriateness of the transfer of the cases to the LTCH.

The Lewin Group was able to calculate a 25% rule payment, which is the lesser of an IPPS equivalent payment and the payment the case would have received under the LTCH-PPS (including the SSO payment if applicable). For this reason, it was possible that not all 25%-rule-eligible cases receive the 25% rule payment. ***Exhibit II.D.1-1*** of the Lewin Report (at p. 24 therein) displays the number of cases eligible for 25% rule payments. Out of the 8,668 eligible cases, 8,172 of them would receive reduced payments. The other 496 were all SSO cases. The average payment for the 8,172 cases decreased from $27,114 before the inclusion of the 25% rule to $10,316 after its inclusion. Lewin Report p. 24. The Lewin Group found that cases subject to the 25% rule had an average length of stay of 25.7 days. Lewin Report, p. 27. Accordingly, LTCHs would receive, on average, only $401.40 per day ($10,316 ÷ 25.7) for patients who become subject to the 25% rule, while the cost per day for these same patients is approximately $1,275. Lewin Report, p. 27. The Lewin Group has calculated that the margins related to patients subject to the 25% rule fall precipitously below costs, so that "average payment for [cases subject to the] 25 percent rule decreases by nearly 62 percent, the estimated margins for 25 percent rule cases are -39.6 percent." *See* Lewin Report, p. 24 and ***Exhibit II.C.5-1*** at p. 21 therein. According to the Lewin Group, "[t]his is further evidence that LTCH cases are not the same as IPPS stays. Therefore, paying LTCHs as if they were IPPS hospitals can lead to extremely disruptive financial situations for LTCHs with a high number cases affected by the 25 percent policy." Lewin Report p. 24. The indicators that the Lewin Group found which indicate that patients who are subject to payment under the 25% rule are different than patients who remain in ACHs are as follows:

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[2] *I.e.*, the date of the last case admitted that is less than 25% of the cases from the discharging ACH.

> We have data on same-day admission cases [who are subject to payment under the 25 percent rule] to LTCHs versus non-transfer cases to LTCHs. . . . Non-transfer cases [cases not subject to the 25% rule] had a LOS of 31.4 days versus 25.7 days for same day admissions; however, the intensity and severity of care seemed to be higher on the same-day admission cases, even though costs per day were similar at approximately $1,275 across case-types. The mortality rate (14.2 percent versus 9.6 percent) and HCO rate from previous hospital (13.1 percent versus 1.2 percent) were significantly higher for same-day admission cases. Lewin Report p. 27.

The Lewin Group observed that they cannot predict which cases will be subject to the 25% rule. However, assuming that the distribution of cases in RY 2008 will be the same as those on the 2005 MedPAR file, the Lewin Group displays in, ***Appendix 5*** of their Report (starting at p. 56 therein), the comparison of the number of covered days and case costs between cases identified as being affected by the 25% rule and IPPS cases for the same DRG. The average number of Medicare covered days for LTCH 25% rule cases was found to be nearly 250% higher than DRG comparable cases in IPPS hospitals. Case costs were found to be approximately 175% higher than cases which group to the same DRGs under IPPS. Mortality rates also were higher in the LTCH cases (11% vs. 7%). Moreover, the Lewin Group has concluded that this data demonstrates that cases paid under the 25% rule are different than IPPS cases as they use different medical resources and require a prolonged hospital stay. This finding, according to Lewin, **"undermines the main justification given by CMS for the [25%] rule."** Lewin Report, p. 27. This data indicates that if LTCHs are unable to change their admission behaviors, the 25% rule will be severely underpaying LTCH cases at IPPS levels and that LTCHs will be at a very high risk for financially catastrophic effects.

We believe that payments under the 25% rule have been demonstrated to be unfair and to grossly underpay LTCHs for the cost of patient care. We have presented data that patients identified as "prematurely discharged" from an ACH by the 25% rule are different in terms of cost, LOS and resource use than cases that remain in ACHs. It is most important that ACH physicians have given testimony that the goal of the 25% rule, which is to deter the admission of Medicare beneficiaries to LTCHs, is harmful to their patients and places an unprecedented regulatory/financial disincentive to their placement of patients in LTCHs for medically necessary care.

E. The Proposed Expansion of the 25% Rule Does Not Reflect Geographic and Market Realities and the OMB's Guidance for Agencies That Use MSAs to Establish Federal Policies.

i. The Secretary Should Clarify Her Policies, Including 42 C.F.R. §412.534(e), to Reflect Core Based Statistical Areas.

The Office of Management and Budget has directed that "all" federal agencies should use the most recent definitions of Metropolitan, Micropolitan and combined statistical areas in collecting data and formulating federal policy. Moreover, it is the "sponsoring agency's

responsibility" (here the Secretary's) to ensure definitions are appropriately used in federal programs. *See* OMB Bulletin No. 06-01. 42 C.F.R. §412.534(e) provides for special treatment of single urban and MSA dominant hospitals on a metropolitan statistical area basis. The most recent OMB definitions of permissible geographic areas for use by federal agencies are Core Based Statistical Areas ("CBSAs"). In 2000, the U.S. Office of Management and Budget ("OMB") introduced "standards [that] replace and supersede the 1990 standards for defining Metropolitan Areas." These standards provided for the identification of various statistical areas, including Metropolitan Statistical Areas and Micropolitan Statistical Areas (*see* p, 2 of OMB Bulletin No 06-01 Appendix available at: http://www.whitehouse.gov/omb/bulletins/fy2006/b06-01_rev_2.pdf). The term "Core Based Statistical Area" ("CBSA") is a collective term for both Metropolitan Statistical Areas ("MSAs") and Micropolitan Statistical Areas (*see* http://www.census.gov/population/www/estimates/metroarea.html). A metro area contains a core urban area of 50,000 or more population, and a micro area contains an urban core of at least 10,000 (but less than 50,000) population. Each metro or micro area consists of one or more counties and includes the counties containing the core urban area, as well as any adjacent counties that have a high degree of social and economic integration (as measured by commuting to work) with the urban core.

There are 951 CBSAs and 440 MSAs. As explained above, the Secretary has an obligation to use CBSAs in policy development. NALTH is unaware of any study or analysis by the Secretary which would justify the use of MSAs in the context of the 25% rule. Accordingly, NALTH requests that the Secretary clarify Section 412.534(e) to reference CBSAs and not just MSAs to define "CBSA dominant" and "urban single" hospitals entitled to "special treatment" under 42 C.F.R. §412.534(e).

NALTH also requests the Secretary to exempt LTCHs (including HwHs) from the 25% rule where there is a single or are a few LTCHs in a CBSA and only one or two ACH referral services in the same CBSA. In this situation, it is virtually impossible for an LTCH to comply with the 25% rule. Moreover, as the Lewin Group has shown at pages 27-29 of its report, a high likelihood exists that a significant number of LTCHs will cease operation due to the 25% rule. This will result in the shifting of patients to remaining LTCHs within a CBSA, making remaining LTCHs more vulnerable to the rule. Thus, the 25% rule, in a real sense, predictably will operate in a self-fulfilling manner, destabilizing the remaining LTCHs in a CBSA. Accordingly, NALTH believes it is important to exempt LTCHs where there are only a few in a CBSA.

ii. The Lewin Group's Review of the Effect of the 25% Rule on LTCH Services Provided in Core Based Statistical Areas[3].

In ***Exhibit II.D.3-1*** of the Lewin Report (at p. 28 therein), Lewin modeled the potential effects of the 25% rule to access to care by CBSA. The Lewin analysis shows that, according to CMS data, there are 169 CBSAs that currently have at least one LTCH in them. The Lewin Group developed decision thresholds used for LTCHs to determine whether to withdraw from the CBSA or not. The decision thresholds are based upon the percentage of the LTCH's cases

that would be impacted by the 25% rule. It is assumed that, if the percentage is greater than the threshold, then an LTCH would be forced to withdraw from the market area. The Lewin Group bases the notion that LTCHs may be forced to cease operations because they will not be able to sustain a significant portion of their cases having close to -40% margins, which is what they estimated the average margin to be for cases impacted by the 25% rule. Lewin Report, p. 31. Thus, if 10% of cases are paid at -40% margins, that would negatively impact total margins by -4%. If 20% of cases are paid at -40% margins, that would negatively impact total margins by -8%. Lewin Report, p. 27.

Exhibit II.D.3-1 (p. 28) in the Lewin Report displays a series of 4 illustrative scenarios showing the distribution of CBSAs by the number of LTCHs located within their borders: (1) There is no 25% rule; (2) LTCHs would withdraw from the market (*i.e.*, shut down) if 30% or more of their cases receive the reduced payment of the 25% rule; (3) LTCHs would withdraw from the market if 20% or more of their cases receive the reduced payment of the 25% rule; and, (4) LTCHs would withdraw from the market if 10% or more of their cases receive the reduced payment of the 25% rule.

The first scenario is a baseline scenario providing a depiction of the count of LTCHs before the implementation of the 25% rule. In this case, of the 169 CBSAs currently containing an LTCH, 87 contain one LTCH and 15 contain 5 or more LTCHs. There are a total of 368 LTCHs located in these 169 CBSAs.

The second scenario displays the number of LTCHs in each of the 169 CBSAs, assuming that LTCHs would withdraw from the market if 30% or more of their cases receive the reduced payment of the 25% rule. In this case, a total of 24 LTCHs would shut down, affecting the availability of LTCHs in 21 CBSAs. There would now be 3 CBSAs that no longer have LTCHs located in them.

Lowering the percentage of cases needed to cause an LTCH to consider withdrawing from the market to 20% increases the number of LTCHs that shut down. This occurs because more hospitals have at least 20% of their cases impacted by the rule compared to 30% as illustrated in the previous scenario. A total of 54 LTCHs would shut down changing the availability of LTCHs in 46 CBSAs. Under this third scenario, there would be 9 CBSAs with no LTCHs in them.

The fourth scenario displays the number of LTCHs in each of the 169 CBSAs assuming that LTCHs would shut down if 10% or more of their cases receive the reduced payment of the 25% rule. Again, more LTCHs have at least 10% of their cases impacted by the 25% rule in comparison to the numbers that have 20% or 30%. Thus, more LTCHs are assumed to shut down. In this illustration, 114 LTCHs would shut down and nearly half (81) of the 169 CBSAs would be impacted. This potentially leads to a dramatic reduction in access for Medicare enrollees to LTCH services, particularly as 35 CBSAs would no longer have any LTCHs.

When thinking about the 25% rule, potentially forcing LTCHs to cease operations (as well as the notion that the 25% rule tends to have a greater impact on hospitals in areas with fewer LTCHs), it seems apparent that the 25% rule has a self-fulfilling tendency. In other words,

as LTCHs withdraw from market areas, an increasing number of LTCHs will be impacted by the rule and could ultimately close as well. The end result essentially would be the end of the LTCH industry, which would leave Medicare beneficiaries lacking important treatment options. Our conclusion provides more than an ample basis for CMS not to expand the 25% rule and to institute a standstill on the phase-in of the rule for HwHs, while it moves forward to implement appropriate patient and facility criteria for LTCHs.

F. CMS Should Intensify and Expand its Review of the Medical Necessity of Care Provided by LTCHs in Lieu of the 25% Rule.

CMS' contractor, the Research Triangle Institute ("RTI") has included, in its Phase II report to CMS, that it has received evidence from some QIOs that some LTCHs may be retaining patients who, while admitted at a hospital level of care, have improved and may be properly cared for in a skilled nursing facility. According to RTI, an LTCH that needs to maintain a 25-day Medicare patient ALOS may "have an incentive to hold on to a patient who could be transferred to a SNF." *See* RTI Phase II Report, p. 67. NALTH believes it is reasonable for CMS to initiate continued stay review in LTCHs, with the objective of identifying patients who convert to a lower than hospital level of care within a few days after admission to an LTCH. These patients likely are patients who could have remained in a referring ACH. This type of review directly responds to CMS' concern that some LTCHs may be admitting patients who should remain in a referring hospital. The objective of the review would be to adjust the count of Medicare-covered days where an LTCH had not made a reasonably timely decision that a patient was no longer at a hospital level of care, thereby providing a disincentive for the admission of a patient who should remain in an ACH. CMS also should increase the sample of cases reviewed for medical necessity of admission to an LTCH. In its March 2007 Report to Congress (at p. 225 therein), MedPAC stated that the current denial rate by QIOs on the 1400 sample of LTCH cases reviewed is 5.9%. Accordingly, MedPAC reiterated its recommendation that CMS use QIOs to monitor the medical necessity of care provided by LTCHs. *See* MedPAC March 2007 Report, p. 229.

G. Each Facility Component of a Multi-Campus Referral Hospital Should Be Regarded as a Separate Referral Hospital for Purposes of the 25% Rule.

Some ACHs have organized themselves as multi-campus hospitals which operate freestanding hospital facilities at multiple locations, within a 35-mile radius, under a single Medicare provider number. Under this model of health care delivery, each campus has characteristics of a freestanding hospital and admits and discharges patients from a single location, like a freestanding referral source. In the event the Secretary does expand the 25% rule, she should regard each campus of a multi-campus referring hospital as a separate location for the purpose of counting patients under the 25% rule. This is important to assure the 25% rule is administered in a fair manner and to avoid penalizing referral hospitals from organizing themselves as multi campus hospital providers.

H. The Proposed Short-Stay Outlier and 25% Rule Policies Destroy the Fundamental Averaging of Payments Which, as CMS Has Acknowledged, Is Essential to any PPS.

It is well established that a PPS does not work in the absence of an averaging of payments, where hospitals receive payments, some of which overpay and some of which underpay the costs of medical resources used by patients. This fundamental premise of how a PPS must operate was made clear by Secretary Schweiker in his seminal report[4] to Congress in 1982, as part of the Health Care Financing Administration's efforts to gain adoption of the IPPS. Since that time, CMS repeatedly has acknowledged that the averaging of overpayments and underpayments is a basic premise of a PPS. The preamble to the current LTCH-PPS proposed rule states this explicitly:

> the Federal standardized payment amount for the IPPS was based on the average cost of an acute care patient across all acute care hospitals. This is premised on the assumption that, on average, both high-cost and low-cost patients are treated at hospitals. Although we might pay a hospital less than was expended for a particular costly case, the hospital would also receive more than was expended for other less costly cases. . . . the foundation of the IPPS DRG payment system . . . is based on averages. . . .
> 72 *Fed. Reg.* at 4809.

It is significant that this averaging requirement is acknowledged in the preamble to virtually every PPS update rule. The preamble to the 2002 final rule establishing the LTCH-PPS states, with regard to the averaging requirement, that "hospitals that are efficient will receive fair compensation." 67 *Fed. Reg.* 56005 (August 30, 2002).

Among its flaws, the proposed 25% policy, along with the SSO policy discussed in more detail below, strips from the LTCH-PPS the central PPS component of averaging overpayments and underpayments. For CMS to repudiate the averaging concept now, which it consistently has advanced in rule-making as the basis for every PPS over the past two decades, makes the proposed rule highly inconsistent and, therefore, arbitrary and capricious. The 25% proposal would invalidate the entire LTCH-PPS. This outcome is unacceptable and, as noted below in Part II. J., contrary to law.

The Lewin Group Report at pages 30 through 31 concludes that:

> the RY 2008 NPRM moves LTC-PPS further away from the concept of averaging. As we noted last year, because a short stay is defined as a stay shorter than 5/6 of the geometric mean length of stay, short stays account for about the same percentage of cases (40 percent) for both ACH and LTCH stays. By defining a short stay in this manner, it is essentially guaranteed that short stays will account for 40 percent of cases. To systematically exclude these cases from the prospective payment averaging system is to abandon the principle of averaging. It is widely recognized that

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

including these types of cases is necessary to produce appropriate averaging for the IPPS; it is equally necessary for the LTC-PPS.

The current LTC-PPS is highly complex and is made even more so by the 2008 NPRM. . . . [T]he premise underlying the proposed rules' very short stay IPPS payments are faulty. From a payment perspective the concept that these new short-stays are very much like IPPS cases is demonstrably false. As we note in ***Exhibit II.C.5-1*** payment margins for these cases is on the order of –17.8 percent. ***Appendix 4*** indicates why this is the case – overall and for most DRGs the LTCH VSSO cases are more resource intensive. To set up a major portion of a PPS with average losses in this range is punitive and strays from a sense of fair play. Under the basic logic of prospective payment systems, you "win" on some cases and "lose" on other cases, but on average, your hospital will be viable**.**

CMS originally argued that LTC-PPS short-stay cases should be paid such that their costs are just covered. This is a retreat from the original IPPS concept of averaging protection through the law of large numbers, but the LTCH industry has adjusted to this. The use of IPPS payment rates to pay for LTC-PPS SSOs is a retreat from the basic notion that PPSs are based on averages such that hospitals win some cases, lose on some others, and, on average, are not placed at undue financial risk. As we note elsewhere, (and show in ***Appendix 3***), LTCH SSO cases require more intensive resource use, by about 46 percent, than the cases that underlie the IPPS payment weights. Indeed, the LTCH SSO cases have an approximately 73 percent longer length of stay than comparable DRGs under IPPS. The PPS was designed to provide incentives for hospitals to reduce lengths of stay and increase efficiencies but also to cover costs of hospitals with average efficiencies.

Under the currently proposed rule, averaging is not only taken away – it is reversed. The very cases required to balance the system as averages would be widely underpaid, and account for over one-third of all LTC-PPS cases. To have over one-third of cases paid at a –8.1 percent margin, and the other 64 percent paid to barely cover or paid slightly less than costs, is an untenable situation, should CMS intend to ensure the stability of care delivery in the LTCH setting.

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

From a clinical perspective the new short-stay outlier policy component seems off the mark as well. Extensive conversations with LTCH physicians and physicians that refer to LTCHs indicate that it is entirely appropriate to move patients out of the acute care hospital setting to the LTCH setting as soon as the patients are stabilized. The acute care hospital is not designed

to provide the team support required to condition patients with complex medical conditions.

There is also the issue of deaths. As we noted, SSO cases have a mortality rate of 23.7 percent and very short stay cases have a mortality rate of 37.8 percent. Because these cases are difficult to predict, we recommend that these cases not be paid under the new policy.

Concerning the 25 percent policy, our SSO analysis indicates that this is not a rational payment policy from an equity perspective. To pay IPPS rates for what appears to be a typical LTCH case is simply not an equitable proposition. Again, with the 25 percent policy, there is no evidence available that this policy will only impact LTCH cases that are similar to IPPS cases or are cases that should have stayed in an acute care setting for a longer period of time. Instead, there is a very high risk that very typical LTCH cases (i.e., cases with much longer ALOS and higher costs than IPPS) will be extremely underpaid using an IPPS based payment.

The resulting overall LTC-PPS margins under the NPRM confirm what the component analyses indicate. The fall from 2.87 (RY 2007) to -0.84 (RY 2008 with NPRM SSO policy) indicates that the proposed rule does not provide adequate coverage for LTCH hospitals. Overall margins drop to -4.3 percent when including the impact of the 25 percent policy in RY 2008. As we noted earlier, we expect the losses to be incurred on 25 percent policy cases (over 6 percent of all LTCH cases) to be even greater than losses for SSO cases. Based on the evidence that LTCHs will not be able to significantly change their admitting procedures to avoid the detrimental financial impacts of the 25 percent policy, we estimate margins of close to -40 percent for these cases.

On page 31 of the Lewin Report, Lewin concludes:

Under the currently proposed rule, averaging is not only taken away – it is reversed. The very cases required to balance the system as averages would be widely underpaid, and account for over one-third of all LTC-PPS cases. To have over one-third of cases paid at a –8.1 percent margin, and the other 64 percent paid to barely cover or paid slightly less than costs, is an untenable situation, should CMS intend to ensure the stability of care delivery in the LTCH setting.

I. Grandfathered Hospitals.

Under 42 C.F.R. §412.22(e), HwHs are excluded from IPPS (*i.e.*, paid under LTCH-PPS), as long as they follow the rules about separate control. Under 42 C.F.R. §412.22(f), HwHs that were excluded from IPPS on or before September 30, 1995 continue to be so excluded,

without having to follow the rules about separate control under subsection (e). The subsection (f) HwHs are "grandfathered" from subsection (e) pursuant to Section 4417(a) of the Balanced Budget Act of 1997, which states:

> Section 1886(d) (1) (B) (42 U.S.C. 1395ww (d) (1) (B)) is amended by adding at the end the following new sentence: "A hospital that was classified by the Secretary on or before September 30, 1995, as [an LTCH] shall continue to be so classified notwithstanding that it is located in the same building as, or on the same campus as, another hospital."

The proposed expansion to the 25% rule would cause grandfathered HwHs to be paid at IPPS rates (for transfers that exceed the 25% threshold), based on CMS' assumption that they are serving as LTCH units of their host hospitals. NALTH contends that grandfathered HwHs should be exempt from the proposed expansion to the 25% rule because Congress explicitly has acknowledged that they are separate from their host hospitals and, therefore, exempt from IPPS. The exemptions afforded to grandfathered hospitals from "control" requirements apply logically to payment requirements. Since Congress has recognized that these HwHs are discrete LTCHs, there is no rational reason for disregarding the separateness that Congress has authorized. In essence, the proposed expansion of the 25% rule to grandfathered hospitals would destroy grandfathered status and, therefore, the proposal is contrary to legislative intent.

Moreover, grandfathered hospitals where exempted from HwH rules by Congress because they existed before these rules where established and were organized without notice of these rules. They are, therefore, not part of the expansion and construction of new LTCHs which are replace existing HwHs and which form the reason for CMS to propose an expansion of the 25% rule. As noted above, grandfathered hospitals seem to be located in CBSAs that would experience serious access issues if the 25% rule were to be extended to freestanding facilities. Accordingly, they should continue to be exempt from the 25% rule.

J. The IPPS Alternative for Payments Violates Federal Law.

i. Statutory Violations.

It is indisputable that Congress specifically excluded from IPPS "a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days." *See* Section 1886(d)(1)(B)(iv)(I) of the Social Security Act (42 U.S.C. §1395ww(d)(1)(B)(iv) (I)). A hospital with an ALOS of greater than 25 days has an absolute right to be paid under the PPS mandated by Congress for that class of hospitals, namely the LTCH-PPS, which applies to cost-reporting periods beginning on and after October 1, 2002. *See* P.L. 106-113, §123.

NALTH's members qualify for reimbursement under the LTCH-PPS because they satisfy the sole standard established by Congress entitling them to reimbursement under that system -- the greater than 25-day ALOS requirement. Services rendered to all patients staying in an LTCH must be paid under the LTCH-PPS. Congress has not prescribed any exception either to this

legislative mandate or to the statutory requirement that a hospital meeting the 25-day standard is excluded from the IPPS.

Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 842-843 (1984) establishes a two-prong test for assessing the validity of a regulation. The first prong involves answering whether Congress has addressed the issue in question in clear language. Here, Congress has addressed the question of whether CMS may subject LTCHs to IPPS reimbursement and, explicitly, has answered that question in the negative. Congress has made two clear pronouncements that must be heeded: there exists a class of hospitals with an ALOS in excess of 25 days and that class of hospitals is excluded from the IPPS. The proposed IPPS reimbursement under the proposed expansion of the 25% rule (and, indeed, under the current 25% rule) violates both of these statutory provisions by subjecting NALTH members to the IPPS for a large percentage of their cases and denying them reimbursement under the LTCH-PPS. As noted above, in 1984, when the Secretary correctly concluded that hospitals such as LTCHs that are excluded from the IPPS "are organized for treatment of conditions distinctly unlike treatment encountered in short-term acute facilities" (ACHs), the Secretary was making a finding that validated the foregoing Congressional requirements. 49 *Fed. Reg.* at 244.

CMS recognizes that it is unlawful to reimburse LTCHs under the IPPS and appears to claim that the words "equivalent to" avoid the illegality. The IPPS "equivalent" payments use IPPS DRG weights, which are derived from ACH charges and reflect ACH resource use and length of stay. The payments to LTCHs cannot exceed an amount "equivalent to" what would be paid under IPPS. Therefore, payment under the proposed 25% rule would, in fact, be an IPPS reimbursement. Resource use by ACHs and LTCHs is different and it was because of this difference that Congress mandated the establishment of the LTCH-PPS. *See* Section 4422 of the Balanced Budget Act of 1997 (P.L. 105-33) and Section 123 of the Balanced Budget Refinement Act of 1999 (P.L. 106-113) (hereafter referred to as "Section 123"). The marked difference between the standard payment amounts under the IPPS and the LTCH-PPS is an empirical acknowledgement by CMS of the different resources used under each system. Paying LTCHs under the IPPS is highly inappropriate from both clinical and payment perspectives.

Throughout the preamble to the proposed rule, CMS repeats the following legislative rationale for its NPRM: ". . . under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of BIPA. . . ." *See*, *e.g.*, 72 *Fed. Reg.* at 4791. CMS also characterizes Section 123 as giving CMS "considerable discretion." 72 *Fed. Reg.* at 4784. Despite CMS' repeated reference to Section 123, the fact remains that Congress has placed limits on the Secretary's authority. Specifically, the directive given to the Secretary to "examine" various subjects under Section 307(b) of BIPA does not translate into authorization to subject LTCHs to the IPPS. Each of these statutory mandates is unaffected by the BIPA amendments.

Although it tries, CMS can not have it both ways. CMS has no authentic claim that payments made under the 25% rule are not IPPS payments because the thrust of its rationale for imposing the 25% rule is that these cases still belong in ACHs and payment should mirror payment to ACHs under the IPPS. LTCHS are entitled to be reimbursed based on LTCH-DRG weights derived from LTCH patient resource use and not on the basis of resource use of patients

treated in another provider type (*i.e.*, an ACH paid under IPPS). It is statutorily implausible to characterize IPPS payments as "equivalent" payments to LTCHs when Congress has mandated a separate payment system for all patients admitted to LTCHs and specifically has required, in Section 123, that payments to LTCHs should reflect the resource use and costs of treating LTCH patients.

ii. The IPPS Payment to LTCHs under the 25% Rule Is Arbitrary and Capricious and Otherwise Illegal.

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

CMS has acknowledged that LTCHs treat "seriously ill" or "medically complex patients" and that the LTCH-PPS was necessary "to reflect the relatively higher costs experienced by LTCHs in treating the most severely ill beneficiaries." *See*, *e.g.*, CMS' April 29, 2005 press release in connection with LTCH payment changes for RY 2006. Therefore, there is no rational justification for the proposed expansion of the 25% rule or for the current 25% rule for that matter. The higher LTCH costs and resource use required to treat seriously ill or medically complex LTCH patients are not reflected in the IPPS methodology. CMS' implication that LTCH patients could be served equally well in an ACH fails to take into account the fact that ACHs do not have a critical mass of these medically complex patients and, therefore, cannot afford to buy the necessary equipment and hire the necessary staff to treat these patients appropriately. As aforementioned in Part II. C. of these comments, even RTI, the expert hired by CMS to look into the appropriateness of LTCH admissions, found 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.* at 4885. ACHs and LTCHs have different missions and organizational structures reflecting these varied missions. CMS attempts to blur these definitions that Congress has addressed so clearly.

b. The Presumption that Cases which Have Not Reached Outlier Status in the ACH Should Remain in the ACH Is Not Clinically Justified.

The impetus for the proposed expansion of the 25% rule arises from CMS' stated concern that cases transferred to an LTCH prior to reaching outlier status at an ACH are "presumably prematurely discharged" from the ACH. 72 *Fed. Reg.* at 4811. As an initial matter, NALTH observes (and has discussed above) that **a discharge decision is made by a patient's attending physician in the patient's best interests**. Similarly, the LTCH admitting decision is made by LTCH clinicians on the grounds that the patient should be able to improve with LTCH care. The medical necessity of any discharge/admission decision neither may be determined nor influenced through a payment mechanism, given the statutory provisions governing medical necessity determinations discussed herein.

CMS' assumption that those cases which exceed the 25% threshold belong in an ACH ignores generally accepted and recognized principles that different health care institutions play

necessary, discrete roles in the continuum of care. Admittedly, LTCHs are acute-level hospitals for Medicare certification purposes. However the 25-day ALOS that distinguishes this class of hospitals from ACHs underscores that the patients served by LTCHs present with different medical issues than those served by ACHs. A physician, exercising medical judgment in the best interests of her/his patient, must determine what type of institution can provide the services required by her/his patient. As aforementioned in Part II. C. of these comments, many cases are served best if they are transferred to an LTCH earlier rather than later. These patients have a better chance of recovering and being discharged home. Requiring that they remain in an ACH until they have reached outlier status, and been exposed to a greater risk of infection and worsened decubiti and nutritional status, is contrary to medical necessity determinations.

For the reasons stated above, CMS' justification for the 25% rule, namely to discourage LTCHs from admitting cases that are "premature" ACH discharges, is unsubstantiated and, most often, demonstrably incorrect. As noted above in Part II. D., MedPAC data[5] showing that admission to an LTCH reduces the chance that a patient will be readmitted to an ACH by 26% further undermines CMS' justification that cases that would be subject to the expanded 25% rule would be "premature" discharges from an ACH to an LTCH. Moreover, CMS' premise also is shown to be faulty by the myriad cases where patients admitted from ACHs are discharged from LTCHs to their home or to a nursing home.

c. The Goals of the 25% Policy Are in Irreconcilable Conflict with the Jurisdiction and Statutory Role of Quality Improvement Organizations ("QIOs").

In June of 2004, NALTH commented on HWH rules proposed by CMS that limited referrals from the host hospital and proposed a ban on common ownership between the HwH and its host hospital. CMS characterized its proposals as admission criteria. *See* 69 Fed. Reg. 28196 at 28326-27 (May 18, 2004). NALTH's objections to the proposed rules focused, in part, on the impropriety of CMS using admission criteria to formulate reimbursement rules.

With respect to the proposed expansion of the 25% rule, CMS avoids the admission criteria characterization it previously employed. However, the IPPS payment reimbursement for those cases that cause the LTCH to exceed its 25% threshold (in both the existing 25% rule and its proposed expansion) represents a *de facto* admission criterion, given CMS' justification for the proposal (namely, a stated concern that the discharge from the ACH, and admission to the LTCH, is "premature"). The question of whether a discharge from any hospital is premature (or, in other words, not medically necessary), is a fact-specific medical question, unique to each affected Medicare beneficiary. This question may not be answered by a categorical, unsubstantiated assertion that an entire class of LTCH cases (*e.g.*, all those exceeding the 25% threshold) should have remained in an ACH setting until they reached outlier status. When CMS claims that these cases should have remained in an ACH setting, CMS actually is taking issue with the numerous medical necessity decisions made by beneficiaries' attending physicians and LTCH clinicians responsible for LTCH admissions, that the beneficiaries' health care needs

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[5] *See* MedPAC's June 2004 Report to Congress, Chapter 5 ("Defining Long-Term Care Hospitals") at p. 127.

would be served best in an LTCH setting. CMS has no statutory authority to second-guess the medical judgments of beneficiaries' attending physicians and LTCH admitting clinicians through a reimbursement proposal. Nevertheless, what CMS actually is doing is engaging in a categorical assumption that attending physicians are violating their duties to their Medicare beneficiary patients simply because they authorize admissions to LTCHs from ACHs prior to the cases reaching outlier status.

Congress has delegated to QIOs the review of "medical necessity" decisions which CMS is trying to override through a reimbursement rule. The statutory and regulatory scheme which vests QIOs with authority to review the medical necessity of hospital services provided to Medicare beneficiaries is both comprehensive and exclusive. The proposed expansion of the 25% rule (and the existing 25% rule, for that matter) inappropriately intrudes on QIOs' authority and beneficiaries' rights, which are provided for explicitly in the QIO review process. A decision regarding the appropriateness of a Medicare beneficiary's admission to an LTCH may not be based on a global, arbitrary assertion that all cases should remain in an ACH setting until they reach outlier status. Instead, it must be based on standards and criteria applied by QIOs. QIOs are established by Sections 1151 *et seq*. of the Social Security Act (42 U.S.C. §1320c *et seq*.). Under these laws, the Secretary delegated to QIOS the responsibility for determining whether or not a patient needs to be admitted to a hospital. *See* Section 1154 of the Social Security Act (42 U.S.C. §1320c-3). The QIO statute affords specific reconsideration and appeal rights to beneficiaries and providers. *See* Sections 1154(a)(3)(B)-(D) (42 U.S.C. §1320c-3(a)(3)(B)-(D)) and 1155 of the Social Security Act (42 U.S.C. §1320c-4). The proposed expansion of the 25% rule is completely incompatible with these rights. Similarly, the pertinent regulation promulgated under the statute, 42 C.F.R. §476.71(a), provides as follows:

> Scope of QIO review. In its review, the QIO must determine (in accordance with the terms of its contract) –
>
> ***
>
> (3) Whether those services furnished or proposed to be furnished on an inpatient basis could, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient health care facility of a different type;
>
> ***
>
> (6) The medical necessity, reasonableness and appropriateness of hospital admissions and discharges;

QIOs issue final determinations (*See* Section 1154(c) of the Social Security Act [42 U.S.C. §1320c-3(c)) and their review is binding on the Medicare program (*See* 42 C.F.R. §476.85).

For more than a decade, CMS declined to include LTCH cases within the QIO scope of work. However, it should be noted that, in accordance with requirements under the final (RY 2003) LTCH-PPS rule (*see* 42 C.F.R. §412.508(a)(1)), CMS authorized QIOs to begin reviewing

the medical necessity, reasonableness and appropriateness of a small sample of approximately 1,400 LTCH admission, continued stays and discharges per year.[6]

CMS' categorical assertion that cases should remain in an ACH until they reach outlier status is completely antithetical to QIOs' case-specific review processes. QIOs employ licensed medical physicians who are designated to review the services provided to Medicare beneficiaries, to determine whether the services were medically necessary, consistent with professionally-recognized standards of care and furnished in an appropriate setting. *See* Section 1154(a)(1) of the Social Security Act (42 U.S.C. §1320c-3(a)(1)). QIOs apply professionally-developed criteria, including screening criteria, to determine whether a case should be referred to one of their physicians for a potential denial. 42 C.F.R. §476.100. QIOs also assess the appropriate medical care available in the community. *See* Section 1154(a)(6)(A) of the Social Security Act (42 U.S.C. §1320c-3(a)(6)(A)) and 50 *Fed. Reg.* 15312, 15316 (April 17, 1985). QIOs are required to establish written criteria based on typical patterns of practice in the QIO area or to use national criteria, where appropriate. *See* 42 C.F.R. §476.100(c). A categorical, arbitrary assertion that all cases must remain in ACHs until they reach outlier status not only lacks factual support (for the reasons noted above), it also is irreconcilably in conflict with the QIOs' statutory responsibility to establish these criteria, which are to operate in the best interest of Medicare beneficiaries.

As aforementioned, QIOs provide for a meaningful review process, with safeguards in place to protect Medicare beneficiaries' interests. *See* Sections 1154(a)(3)(B)-(D) (42 U.S.C. §1320c-3(a)(3)(B)-(D)) and 1155 of the Social Security Act (42 U.S.C. §1320c-4) and Section 4530 of the QIO Manual. The rights secured to beneficiaries and their physicians, which irreconcilably conflict with the proposed IPPS payment for cases exceeding the 25% threshold, include the right for an attending physician to be afforded the opportunity for discussion with a QIO reviewer prior to a determination (Section 1154(a)(3)(B) of the Social Security Act (42 U.S.C. §1320c-3(a)(3)(B))). The regulation adopted under this Section requires an explanation of "the nature of the patient's need for health care services, including all factors which preclude treatment of the patient as an outpatient or in an alternative level of inpatient care." 42 C.F.R. §476.93. Moreover, the QIO Manual contains guidelines which encourage an opportunity for discussion between the attending physician and a QIO physician of the same specialty. *See* QIO Manual, §4530.

The QIO regulatory process provides for physician-to-physician discussion and appeal rights, consistent with the statute, which would be impaired by the proposed expansion of the 25% rule, an option that basically deems all pre-outlier admissions to LTCHs to be medically unnecessary. For example:

- Under 42 C.F.R. §476.93, before making an initial determination or a change as a result of DRG validation, the QIO is required to notify the provider and the patient's attending physician of the proposed

[6] QIOs found a 29% denial rate in this sample in 2004. *See* MedPAC's March 2006 Report to Congress, Chapter 4C ("Long-Term Care Hospital Services") at p. 211.

determination or DRG change and afford them the opportunity for discussion with the QIO physician advisor.

- Under Section 1154(a)(3)(B)-(D) of the Social Security Act (42 U.S.C. §1320c-3(a)(3)(B)-(D)) and 42 C.F.R. §476.94(a)-(c), in the event of an initial denial or change in DRG validation, the QIO is required to provide written notice to the patient, attending physician and the provider and afford them with a right to request a review or reconsideration of the determination.

- Under Section 1155 of the Social Security Act (42 U.S.C. §1320c-4) and 42 C.F.R. §478.40, if the request for reconsideration results in a denial and the amount in controversy is $200 or more, a beneficiary has the right to request a hearing before an Administrative Law Judge of the Office of Medicare Hearings and Appeals.

- Under Section 1155 of the Social Security Act (42 U.S.C. §1320c-4) and 42 C.F.R. §478.46(b), if the Administrative Law Judge ruling is unfavorable and the amount in controversy is $2,000 or more, a beneficiary has the right to seek judicial review.

To ensure consistency among determinations and avoid confusion among providers and beneficiaries, it is important that any admission to an LTCH be consistent with the QIO screening criteria and utilization review processes. Applying a strict, *per se* rule (that any admission of a case to an LTCH prior to its reaching outlier status at the referring ACH is presumed "premature" and inappropriate), is totally antagonistic to QIO procedures and standards, defeats important patient rights and directly interferes with the professional judgment of clinicians as to the most appropriate provider of care for beneficiaries. We have demonstrated (at p. 16, *supra*) that payments under the 25% rule, at $401 per day fall far below hospital cost. Payments this low constitute a virtual direction for LTCHs not to admit patients who may be paid under the 25% rule.

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

The Medicare program should not establish a *per se* rule which conclusively presumes that any admission to an LTCH from an ACH, where the case has not yet reached outlier status at the ACH, is a premature discharge from the ACH. Such a *per se* dictate is flawed not only because, as aforementioned, the dictate cannot be justified factually or medically but also because it undermines the freedom of choice that the Medicare program consistently has recognized as a beneficiary entitlement. The idea that patients who qualify for medically necessary LTCH services may be forced to remain for treatment in an ACH setting due to inadequate LTCH payment cannot be reconciled with patients' freedom of choice entitlement.

The stated premise behind the proposed expansion of the 25% rule is that the admission of any pre-outlier case from an ACH to an LTCH is inappropriate because it is "premature." Starting with this bald, unsubstantiated premise that is contrary to attending physician determinations of medical necessity, CMS posits that no pre-outlier case should be admitted to an LTCH. Rather, CMS concludes that all such cases should remain in an ACH setting. To abide by CMS' unsubstantiated assumptions, LTCHs should not admit (and actively are discouraged from admitting) any pre-outlier cases. The means of enforcement through payment, while indirect, still thwarts beneficiary choice as mandated by the Congress.

These consequences are directly contrary to Section 1802(a) of the Social Security Act (42 U.S.C. 1395a(a)), which provides that any Medicare beneficiary "may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services." In recognition of this statutory requirement, the Medicare program routinely advises program beneficiaries that they "can go to any doctor, supplier, hospital, or other facility that is enrolled and accepts Medicare and is accepting new Medicare patients." *See* the CMS Publication "Medicare & You: 2007" at p. 25. This Medicare publication, which is provided to every Medicare beneficiary, goes on to state: "you have [the right] to . . . "go to Medicare-certified hospitals." *Id* at p. 82. These statements are derived directly from Section 1802(a) of the Social Security act and embody the freedom of choice guarantee that the fee-for-service Medicare program has extended to all program beneficiaries. Medicare program beneficiaries are not advised that their ability to receive medically necessary services in an LTCH is categorically inappropriate if they come to the LTCH from an ACH prior to reaching outlier status.

The proposed expansion of the 25% rule (as well as the existing rule) is contrary to the freedom of choice compact which the Medicare program has made with program beneficiaries. Full freedom of choice access to LTCHs, and the physicians who practice therein, cannot be withdrawn or restricted merely because a beneficiary, supported by a medical necessity determination by her/his attending physician, happens to require admission to an LTCH from an ACH prior to reaching outlier status. The notion that patients who qualify for medically necessary LTCH services may be forced to remain for treatment in an ACH setting due to inappropriate LTCH payment cannot be reconciled with patients' freedom of choice entitlement.

In NALTH's view, the *per se* dictate that, to avoid ultra-low payments under the 25% rule, all cases should remain in an ACH until reaching outlier status, gives rise to notice of non-coverage issues. Must an LTCH which denies a beneficiary admission for medically necessary care in reliance upon the *per se* dictate proposed by CMS provide a notice of non-coverage to the beneficiary? At a minimum, the Secretary should address both whether and why a notice of non-coverage is or is not necessary. NALTH submits that, in the circumstances identified, a notice of non-coverage may be required by 42 C.F.R. §411.404 and Section 414.3(B) of the Medicare Hospital Manual (CMS-Pub. 10). A beneficiary who believes that s/he has been denied covered services by an LTCH, regardless of whether a notice of non-coverage is issued, has an unqualified right to request reconsideration by a QIO under Section 1155 of the Social Security Act (42 U.S.C. §1320c-4). A beneficiary has other appeal rights, including review by an administrative law judge (42 C.F.R. §478.12(b)(2)(i)) and judicial review (42 C.F.R. §478.12(b)(2)(ii)). These appeal rights focus on the medical necessity of services sought by a

beneficiary. As noted above, a coverage determination by a QIO is binding on the Medicare program and on a provider. *See* 42 C.F.R. §476.85. Assuming LTCHs deny admission on the basis of whether a case has reached outlier status yet and will not be reimbursed adequately, it is important that the Secretary, in the final rule-making, address the question of how denials of covered services by LTCHs relate to beneficiaries' rights to receive notices of non-coverage and relate to the function of QIOs.

III. Revisions Being Considered to SSO Payment Methodology.

The comments which follow focus on the new SSO proposal that CMS is considering. However, the comments apply with equal force to the existing SSO payment requirements, with which NALTH previously expressed its disagreement. The new concept being considered by CMS to reduce payment further for a "very short stay outlier" simply will compound the negative and unwarranted effects of the SSO rule on LTCH finances as well as negative impacts on Medicare beneficiaries. Any use of the IPPS to reimburse for services to patients in an LTCH is inappropriate and will destroy the concept of averaging underlying the establishment of LTCH-PPS rates of payment. The policy under consideration will expand the payment losses already experienced by LTCHs in serving SSOs and, predictably, may result in patients remaining longer in ACHs and thereby experiencing adverse medical outcomes.

A. Background.

Under the current LTCH-PPS SSO payment adjustment policy (located at 42 C.F.R. §412.529), an LTCH discharge with an LOS that is up to and including five-sixths of the geometric ALOS for the applicable LTC-DRG is considered an SSO and is paid the lower of:

i. 120% of the LTCH-DRG specific *per diem* amount (multiplied by the covered LOS of the case);
ii. 100% of the estimated cost of the case;
iii. The Federal prospective payment for the LTCH-DRG; or
iv. An amount ... computed as a blend of an amount comparable to the IPPS *per diem* amount and the 120% of the LTCH-DRG specific *per diem* payment amount.

In the preamble to the proposed update rule, CMS states that it is considering a change to the payment rules for an SSO whose covered LOS in the LTCH is "equal to or less than the IPPS comparable threshold" (*i.e.*, equal to or less than the IPPS LOS plus one standard deviation for the same DRG). For LTCH discharges that meet this criterion as a very short stay outlier, the final SSO payment benchmark would be changed by replacing the blend in the current rule that was implemented just last year with an "LTCH PPS amount comparable to the IPPS per diem amount . . . <u>not to exceed the full IPPS comparable amount</u>." 72 *Fed. Reg.* 4807, emphasis added.

NALTH **strongly objects** to the revision to the current SSO payment policy that is under consideration. NALTH's objections are based on clinical, policy and legal grounds. As detailed below, NALTH believes that the idea of reduced payments for very SSO patients fails to reflect the different resources provided at LTCHs, results in significant financial losses for LTCHs in

serving these patients, profoundly distorts the LTCH-PPS and violates important primary directives of the Social Security Act.

The Lewin Group used 2005 Medicare Provider Analysis and Review ("MedPAR") data, similar to what CMS used, in its impact analysis and, among other things, determined that approximately 31% of SSO cases and 11% of total LTCH cases would be reimbursed under the very short stay policy being considered, in which an IPPS payment would become the *de facto* controlling alternative under the "lower of" options. Lewin Report pp. 16-17 (including ***Exhibit II.C.2-1***)[7]. LTCHs would experience negative margins of -17.8% for very SSO cases and -8.1% for all SSO cases. *See* Lewin Report ***Exhibit II.C.5-1*** (at p. 21 therein). This would result in devastating financial consequences to LTCHs.

One alternative suggested by Lewin is that CMS could use percentiles as thresholds that are based on the LTCH LOS distributions by DRG. Lewin provided two simulations for this showing that the current law's threshold is not statistically justifiable. If CMS is going to use LOS as the only criteria for selected outliers, it logically should choose a threshold that better isolates cases that are dissimilar to the median and/or average case. For instance, the 5th percentile through 10th percentile from a statistical perspective better reflect the concept of outliers. The NPRM sets out payments that reflect about the 37th percentile paying at the NPRM's blend amounts and about the 42nd percentile paying at cost. Lewin Report, 38.

B. The Policy Predicate to the SSO Proposal, that the Number of SSO Cases Is Excessive, or Are Somehow Clinically Comparable to Patients Admitted to Acute Care Hospitals, Is Not Stated in Careful Clinical Terms and Is Factually Wrong and Logically Flawed.

The reasons and rationales proffered by CMS for this possible change in Medicare payment policy are steeped in the assumption that SSO patients in LTCHs are in the same episode of care as they were in while at the ACH, that they receive the same resources as they did while at the ACH and that payment under the IPPS is reasonable and appropriate for these cases. The objective of the very SSO policy under consideration effectively is to establish a prohibition of the admission of these patients to LTCHs through the use of a payment mechanism as opposed to a careful clinical review. For example, the preamble to the rule states that:

> . . . a short stay case at a LTCH most likely did not receive a full course of medical treatment during the short stay and . . . a full LTC–DRG payment would therefore, be inappropriate"
> 72 *Fed. Reg.* at 4804.

> and

[7] To calculate the 11%, take the number of "Comp Full IPPS" cases in ***Exhibit II.C.2-1*** and divide by "All LTCH Discharges" therein (14,605 ÷ 130,599 = 11.18%).

> . . . we believe the approach discussed for the SSO policy could be appropriate, given that many of these SSO cases that are ''similar to IPPS cases'' most likely do not receive a full course of a LTCH-level of treatment in such a short period of time since, in general, LTCHs are intended to treat longer stay patients. Furthermore, since by far the majority of SSO cases were admitted to the LTCH directly from an acute-care hospital, they are likely to still be in need of acute-level care at the time of admission to the LTCH. We believe that this may indicate that the LTCH admission is a premature and inappropriate discharge from the acute-care hospital and an inappropriate admission to the LTCH. We believe that the approach for the SSO policy could result in appropriate payments for short-stay cases treated at LTCHs . . . .
> 72 *Fed. Reg.* at 4840.

Therefore, it is clear that CMS is attempting to supply a *de facto* exclusionary policy, through the LTCH payment system, for patient admissions to LTCHs. The sole reason advanced in support of this position is that care for a patient with an LOS similar to that of an ACH patient should be paid at IPPS rates. In Part III. H. of these comments, below, NALTH presents its views that the engineering of patient access and admission to a hospital, including an LTCH, through mechanisms in a payment system, violates federal law.

i. CMS Fails to Present Clinical Data to Support its Assumptions.

CMS does not present any hard, conclusive financial or clinical evidence to support its policy but, instead, makes statements that "[w]e believe that when these patients are admitted to a LTCH for an extremely short stay, the LTCH <u>appears</u> to be serving as a step-down unit of the acute care hospital" 72 *Fed. Reg.* at 4806 (emphasis added). CMS also mentions its belief that "many LTCHs <u>appear</u> to be admitting some SSO patients that could have received the care at the acute care hospital." *Id*. (emphasis added). As with the proposed expansion of the 25% rule, a policy that will cause serious adverse financial harm to LTCHs, as well as have potentially negative medical care implications for Medicare beneficiaries, should be based on more than CMS' belief. There simply is a lack of data to support CMS' taking of such drastic action and even CMS' own hired, expert consultant, RTI, has not found evidence conclusively showing that the typical LTCH SSO patient could be treated as effectively in an ACH (*see* 72 *Fed. Reg.* 4885).

ii. CMS Does Not Yet Know the Results of its Recent SSO Policy Change.

One initial disagreement NALTH has with the consideration of the very SSO rule is that CMS does not yet have data to analyze the results of the change made last year to the SSO rule that added the fourth payment criterion, that is, the blend of the IPPS and LTCH-PPS payments. Last year NALTH, with the assistance of Lewin, presented vivid data as to why the use of any IPPS payment criterion was inappropriate and could harm patients, as well as LTCHs. It appears hasty and presumptuous to consider making further changes to a disputed and questionable payment methodology when the impact of the existing rule is not yet known.

iii. There Are Not "Too Many" SSO Cases.

CMS believes that there are too many cases that may be deemed to be short stays, which number demonstrates an industry incentive to transfer patients too early from the ACH setting to an LTCH and thereby interrupt a single course of treatment. Statistically, stays less than 5/6 of the geometric mean *always* will account for about 30-40% of cases, regardless of the expected-stay threshold the LTCHs require for an admission. "By defining a short stay in this manner, it is essentially guaranteed that short stays will account for about 30 to 40 percent of cases. To object that this is "too many" is akin to objecting to the fact that LTCHs have 50 percent of cases that are below the median.". Lewin Report, p. 18.[8] Lewin shows that, for 2005, 36% of LTCH-PPS cases are SSOs, the inevitable predicted amount. Lewin Report, pp. 18 and 19. Similarly, IPPS hospitals and hospitals under any other prospective payment system for that matter would have had a similar percentage of SSO in that year. *Id*. The results for LTCHs, then, is not unexpected or demonstrative of wrongdoing or game-playing by the LTCH and ACH industries. It essentially is impossible for LTCHs to admit a smaller number of SSOs in any given year, given the CMS definition of an SSO as one with an LOS of less than 5/6 the geometric mean LOS.

Lewin also has demonstrated that LTCH SSO cases, especially the very SSO cases under consideration, should not be paid under the IPPS inasmuch as that system completely fails to consider the significant differences in LOS, intensity and severity between IPPS and LTC-PPS cases. "Even though the average number of covered days is about 18 percent less, costs are about 13 percent more for LTC-VSSO cases." Lewin Report, p. 20.

iv. Deaths Should Be Excluded from the SSO Policy.

One clear aspect of the higher intensity of the LTCH SSO cases is demonstrated by the fact that, in 2005, almost 24% of the LTCH SSOs ended with the death of the patient, nearly twice as high as for all LTCH cases, whereas only 4.3% of the IPPS would-be SSOs ended with deaths. *See* Lewin Report at p. 3, and ***Exhibits II.C.3-2*** (at p. 19) and ***II.C.4-1*** (at p. 20). These results are similar to what Lewin found based on 2003 and 2004 data, so there is a clear and consistent pattern in this area and the pattern is that LTCH SSOs are sicker, more severely ill, and use more resources than corresponding ACH cases. If the very SSO policy discharges are considered, the number of deaths jumps to almost 38% of the very SSO cases (Lewin Report, p. 3 and ***Exhibit II.C.4-1*** at p. 20 therein), nearly three times as high as all LTCH cases, and the margins for these cases is a loss of over 17% (Lewin Report, ***Exhibit II.C.5-1*** at p. 21). Many studies have shown that these cases are very expensive in the hospital setting. Particularly

[8] "***Appendix 2*** shows the 50 DRGs in the 2005 LTCH MedPAR data with the highest number of short stay cases. This indicates that, by and large, LTCH DRGs show a consistently high percentage of SSO cases -- in the 30 to 45 percent range, which further indicates that the large portion of SSO cases is due to the CMS definition of SSOs and not LTCH patient selection. That is, even for DRG 565 and 566, dealing with patients needing ventilator support, which are the patients most often cited as the patients associated with appropriate LTCH care, a large number of SSO cases are selected. This does not seem to support the notion that the SSO policy impacts cases that should not be treated in LTCHs. Instead, it lends evidence that it arbitrarily selects cases regardless of the appropriateness of the treatment setting." Lewin Report, p. 18.

troubling is the fact that deaths are difficult for LTCHs to predict at admission. It is unfair and illogical to penalize LTCHs, and to pay them at an extremely low IPPS comparable amount, for these sick and resource-intensive cases. CMS should exclude these cases from the SSO policy and, instead, should pay these cases as regular LTCH-PPS discharges, just as CMS pays ACHs a full IPPS amount for cases that result in deaths in ACHs.

v. SSO Cases Are Far More Resource-Intensive and Expensive than Corresponding IPPS Cases on a DRG-by DRG-Basis.

Lewin also proved that the LTCH SSO cases are far more resource intensive than IPPS discharges and are more severely ill than IPPS cases. The Lewin data shows that LTCH SSO cases last over 70% as long, on average, as IPPS cases in the same DRGs. Lewin Report, p. 3. Moreover, the payment margin under LTCH-PPS for SSO cases is -8.1%. Lewin Report, ***Exhibit II.C.5-1*** at p. 21. Inasmuch as SSO cases represent about 40% of all LTCH-PPS cases (Lewin Report, p. 18), this financial result cannot be said to be reasonable, sustainable or consistent with financial margins that are generally understood by providers and regulators in the industry to be necessary for providers to maintain operations.

vi. LTCHs Have No Incentive to Admit a Patient "Prematurely."

The current SSO policy ensures that an LTCH will receive, at best, only the cost of the case. Thus, there is no financial incentive for an LTCH to admit a patient "prematurely," as CMS states. Accordingly, CMS' justification for the very SSO IPPS option is unsubstantiated.

vii. SSO Cases with Long ALOS Should Be Excluded from the SSO Policy.

The statutory classification requirement to be an LTCH – an LOS which, on average, exceeds 25 days – contemplates a distribution around that average, with LOSs which are higher and lower than 25 days. CMS' purported rationale for both the current SSO policy and the contemplated very SSO policy is factually incorrect, since many of the cases that fall within the SSO policy are not really short stays at all.

CMS' consideration of the very SSO payment penalty, if an SSO patient remains in an LTCH for a period equal to or less than the IPPS ALOS plus one standard deviation, fails to recognize that at least nine (9) IPPS DRGs have an ALOS plus one standard deviation of greater than 25 days,[9] the statutory definition of an LTCH. Moreover, there are at least twenty-six (26) IPPS DRGs with an ALOS plus one standard deviation that exceed 20 days. *See* Table 3 of the proposed rule. Thus, there are numerous patients whose stay at an LTCH cannot be said to be short stays at all, and cannot, based solely on the length of stay, be conclusively presumed to be an improper admission to an LTCH. There is absolutely no clinical support for CMS' assumption that a discharge prior to the patient's reaching the IPPS ALOS plus one standard deviation is inappropriate.

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[9] We assume that the IPPS ALOS plus one standard deviation of 360.4 for DRG 314 on Table 3 of the proposed rule (at page 4878) is a typographical error.

A similar conclusion can be reached with respect to the current SSO policy. Lewin has found that 14.7% of the cases deemed to be SSOs in fact had a LOS of 20 or more days. *See* ***Exhibit II.C.3-2*** at p. 19 of the Lewin Report. These cases can not, and should not, be considered as short stays or somehow improper cases to be treated at an LTCH.

viii. Cases that Were High-Cost Outliers at the ACH Should Be Excluded from the SSO Policy.

CMS contends that SSO cases should not be paid under the LTCH-PPS because the LTCH admission is a "premature and inappropriate discharge" from the ACH and an "inappropriate admission" to the LTCH. 72 *Fed. Reg.* at 4840. There are cases, however, in which the patient reached high-cost outlier status at the ACH prior to being transferred to the LTCH. Inasmuch as these cases received a full complement of services at the ACH and CMS will pay the ACH additional amounts in recognition of this fact, CMS should not then argue that the discharge to the LTCH was premature and inappropriate. Cases that reach high-cost outlier status at the ACH should not fall under CMS' SSO policy for LTCHs.

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

As noted above, CMS asserts, without any clinical evidence, that LTCHs appear to be serving as step-down units for ACHs and that LTCHs appear to be admitting some SSO patients who could have received the care at an ACH. In fact, the care received by patients at LTCHs often is unique and not available at an ACH. Physicians at ACHs make the determination to discharge a patient to an LTCH based upon the best interests of the patient and the particular services that can be found at the LTCH. The policy objective underlying the SSO rule is to preclude LTCHs and physicians, through the imposition of a severe financial penalty, from admitting patients who might become SSOs and, even more disastrously, a very SSO patient under the new policy being considered by CMS. CMS effectively is making the unilateral medical decision that these patients should not be admitted to LTCHs on payment grounds alone. The assumption underlying this admission initiative is unsupported and untrue.

As Lewin has discussed at length in its report, physicians at both ACHs and LTCHs were consulted to discuss the clinical aspects of the decision-making behind the transfer of a patient from the short-term ACH setting to the LTCH, including the timing of the transfer. There were numerous explanations given of how LTCHs provide different types of services to patients, even if the DRG for the case is nominally the same at both hospitals. Moreover, numerous scenarios were given in which keeping a patient at an ACH until the high-cost outlier status was achieved, thereby delaying the patient's discharge to an LTCH, could have serious and irreversible consequences for the patient. Using a non-clinical financial approach to solve a perceived but unproven problem is illogical, inequitable and ultimately will harm LTCHs and their patients.

The unique services provided by LTCHs, and their significant contribution to improving the medical outcomes of certain classes of patients, was demonstrated in clear terms. In the

course of conducting its research and educational activities, NALTH sponsored a study[10] of the characteristics of patients admitted to LTCHs who were in respiratory failure and on ventilator support. NALTH believes that this is the most careful and best-documented clinical study of the efficacy of LTCH care. This multi-site study, conducted by the Barlow Respiratory Hospital Research Center, included data on 1,419 patients who were admitted to 23 LTCHs located throughout the United States that have active ventilator weaning programs. Most, if not all, LTCHs embrace the multidisciplinary, rehabilitative model of care for weaning patients from prolonged mechanical ventilation.

Of all the patients studied, 453 (32%) had stays of less than 29 days, which means they would qualify as SSOs because they would be assigned to DRG 565 (respiratory system failure with ventilator support), for which 5/6 of the geometric average LOS is 28.9 days. Prior to transfer to the LTCH, 93.9% of the patients were in an ICU, with an additional 4.2% transferred from "step-down" or monitored units. Patients transferred to LTCHs for weaning from prolonged mechanical ventilation are elderly with severe acute illness superimposed on chronic disease. This population requires extensive, continued treatments and interventions at an LTCH, not only for respiratory failure but also for numerous pre-existing conditions, co-morbidities and complications, the latter predominantly being infections. In short, these patients were failing at ACHs and were admitted to LTCHs for ventilation weaning, which could not be done as successfully at ACHs. Despite advanced age and numerous co-morbidities and complications, and despite the fact that **all of these patients already had failed multiple weaning attempts at the ACHs**, more than 50% of all patients enrolled in the study were weaned successfully from mechanical ventilation at the LTCHs. The rate of survival to discharge was 74.8%, illustrating that LTCHs, with their specialized programs of care, safely can wean a population with exceptional medical challenges. Nearly 30% of the patients returned directly home or to assisted living facilities following discharge from the LTCH. Furthermore, a year after admission to the LTCH, nearly two-thirds of survivors reported good functional status.

If the very SSO policy under consideration by CMS were to achieve its objective, LTCHs would have a disincentive to admit many ventilator-dependent patients. As a result, Medicare beneficiaries, such as those who were successfully treated in this study, would not be provided the opportunity to receive care under the multidisciplinary team and programmatic approach available in LTCHs which could result in their becoming weaned from their ventilators. The "opportunity cost" of not being admitted to an LTCH could be tragic for those patients.

The ventilator weaning study sponsored by NALTH is illustrative of the broad range of Medicare beneficiary patients who would not improve in the absence of receiving care in an LTCH. As noted in Parts II. D. and II. J. ii. b. above, MedPAC has found that patients treated in LTCHs have a 26% less frequent readmission rate to ACHs than similar patients who are not treated in LTCHs.[11] In order to be readmitted to an acute care hospital, a patient's condition must deteriorate and the patient must be medically unstable. Under the very SSO policy under consideration, the 14,605 very SSO Medicare beneficiaries which the Lewin Group found to

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

[11] *See* MedPAC's June 2004 Report to Congress, Chapter 5 ("Defining Long-Term Care Hospitals") at p. 127.

exist in 2005 (Lewin Report, ***Exhibit II.C.2-1*** at p. 17) would be placed in harm's way and, according to MedPAC's finding, would face a higher degree of morbidity.

D. The Very SSO Policy Will Result in Significant Financial Losses for LTCHs.

Even if the very SSO policy under consideration eventually is enacted and LTCHs and ACHs alter their behavior to limit the number of very SSOs being admitted to LTCHs, there undoubtedly will be a number of these cases that will be presented at LTCHs. Lewin's projections is that the very SSO policy will decrease payments for SSO cases by 6.2% (with a -2.2% effect on overall Medicare margins), and for very SSO cases payments will decrease by nearly 24%, with a -2.6% effect on overall Medicare margins. Lewin Report p. 3.

Significant financial losses by LTCHs in treating any SSO cases is predictable, given that IPPS case LOS, intensity, case mix and severity are far below the corresponding numbers for LTCH-PPS, and the Lewin analysis proves this to be the case. Overall, the LTCH-PPS payment margin for LTCH SSO cases is a negative **-8.1%**. Lewin Report, ***Exhibit II.C.5-1*** at p. 21.

E. The SSO Policy Under Consideration Improperly Reduces Payment for Patients Who Are Not SSO Cases but Who Exhaust their Medicare Coverage.

One consequence of the proposed very SSO policy is that it would penalize LTCHs when they admit very ill patients who have a long length of stay but who exhaust their limited Medicare day benefit prior to reaching the IPPS ALOS plus one standard deviation for the applicable DRG. CMS labels these long-stay patients as short-stay patients for billing purposes and drastically underpays the cost of their care. These patients usually are medically indigent. The SSO policy directed at keeping all patients whom CMS characterizes as short-stay patients for billing purposes out of LTCHs, even though they are, in fact, long-stay patients, is irrational. CMS should exclude patients who exhaust Medicare coverage from both the current SSO policy and the very SSO policy being considered.

An especially troubling consequence of the proposed SSO policy is that so much money would be taken out of the LTCH-PPS that the cost threshold for treating longer-term, HCO patients would be increased from $14,887 to $18,774. 72 *Fed. Reg.* at 4800. The mathematical effect of the proposed SSO policy would be to penalize LTCHs in two ways: first for treating patients CMS defines as short-stay patients and then again for treating those whom CMS acknowledges to be extraordinarily high-cost, long-stay patients. This consequence is unfair on its face, destroys the policy of averaging payments, discussed above in Part II. H. of these comments, and is arbitrary and capricious. CMS has not explained how LTCHs will finance the higher costs of these unusually long-stay patients. It makes no sense to treat cases with long stays as SSOs.

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

CMS does not suggest any manner in which physicians or LTCHs can predict which patients will become SSOs. LTCHs admit patients under standards and processes required by

QIOs and hospital utilization review committees. CMS knows that there are no standards which can predict the course of a patient's medical condition when s/he is admitted to any health care provider. When an LTCH is successful in improving a patient's condition to the extent that the patient can be discharged prior to staying as long as the IPPS ALOS plus one standard deviation for the applicable DRG, the LTCH is acting in the best interest of the beneficiary and cannot rightly be penalized by CMS. Similarly, when, for example, a patient expires or when s/he leaves an LTCH for surgery due to complications of her/his medical condition, it is irrational to fault the LTCH. CMS, in effect, is attempting to achieve a complex clinical result with a regulation. It is inconceivable that this approach can be effective. Either patients will be harmed or LTCHs will suffer unsustainable financial losses. NALTH points out that, prior to the establishment of the LTCH-PPS, patients were discharged to ACHs to receive treatment for such events as heart attacks. The cost of these services are not accounted for in the LTCH-PPS federal standard amount.

G. Patients Admitted from Other Than An Acute Care Hospital Should Be Excluded from the SSO Policy.

As noted above, CMS predicates its current SSO policy, as well as the very SSO policy now under consideration, on its belief that these cases should be paid at the IPPS rates because they represent the continuation of one episode of care from the ACH admission. CMS specifically states:

> Furthermore, since by far the majority of SSO cases were admitted to the LTCH directly from an acute-care hospital, they are likely to still be in need of acute-level care at the time of admission to the LTCH. We believe that this may indicate that the LTCH admission is a premature and inappropriate discharge from the acute-care hospital and an inappropriate admission to the LTCH.

72 *Fed. Reg.* at 4840.

Despite this rationale, CMS applies the SSO policy to the 20%[12] of the discharges from an LTCH that were <u>not</u> admitted from an ACH. It is illogical to apply a financial penalty designed to halt premature admissions from an ACH to those cases that do not arrive from an ACH. These cases should be excluded from the current SSO policy as well as the very SSO policy under consideration.

H. The IPPS Alternative for SSO Payments Violates Federal Law.

The arguments made in Part II. J., above, in relation to the 25% rule, are equally applicable to CMS' consideration of a very SSO policy. Without repeating them in full here, NALTH briefly summarizes them as follows:

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[12] *See* Lewin Report, p. 23 (footnote 26).

i. Statutory Violations.

Congress specifically excluded LTCHs from IPPS under Section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. §1395ww(d)(1)(B)(iv)). CMS' consideration of a very SSO policy is invalid under the *Chevron* test. Congress has addressed the issue in question in clear language. An LTCH has an absolute right to be paid under the LTCH-PPS. *See* P.L. 106-113, §123. Therefore, the consideration of IPPS reimbursement for very SSO cases violates statutory provisions. Congress has mandated a separate payment system for all patients admitted to LTCHs and specifically has required, in Section 123, that payments to LTCHs reflect resource use and costs of LTCH patients.

ii. The IPPS Alternative for SSO Payments Is Arbitrary and Capricious and Otherwise Illegal.

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

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

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

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

The impetus for the IPPS SSO payment option arises from CMS' stated concern that SSO cases "may have been transferred from an acute hospital prematurely." 72 *Fed. Reg.* at 4804. This is incorrect. First, like cases that would be subject to the proposed 25% rule, **a discharge decision is made by a patient's attending physician in the patient's best interests**. CMS may not determine the medical necessity of any discharge or admission by using a payment mechanism. Rather, there are statutory provisions governing medical necessity determinations.

Second, it is misguided for CMS to assume that all SSO cases should remain in ACHs. In fact, a significant number of SSO admissions to LTCHs do not come from ACHs but rather, as directed by a patient's attending physician, come from the patient's home, an assisted living facility or a skilled nursing facility.[13] It is incorrect for a payment option to assume that a patient admitted to an LTCH from a non-acute hospital setting at the direction of the patient's attending

[13] Lewin Report, footnote 26 at p. 23 shows that 20% of LTCH admissions come from non-ACH locations.

physician and whose case becomes an SSO, was admitted from an ACH. In this case, the attending physician, exercising medical judgment, regarded an ACH admission as inappropriate and admitted the patient directly to an LTCH.

Third, it is illogical to presume that a patient admitted to an LTCH from an ACH who becomes a very SSO case due to death should have remained in the ACH. For example, it is irrational to presume that a patient requiring ventilator services or specialized rehabilitation services not available in an ACH but offered by an LTCH should have remained in the ACH solely because the resident expired shortly after admission to the LTCH. The same is true for a patient who had to be transferred to an ACH for an unexpected surgery. As noted above, there are times when patients are languishing in ACHs when they should be (and would benefit from being) transferred to an LTCH.

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

Fifth, one must not forget that the current SSO policy already ensures that an LTCH will receive, at best, only the cost of the case. Therefore, there is no financial incentive for an LTCH to admit a patient "prematurely," as CMS puts it. At the same time, ACHs do not have an incentive to discharge many of these cases early because of the transfer rule, which reduces payment to an ACH if the patient is admitted to another hospital prior to the patient reaching the ALOS for the applicable DRG (*see* 42 C.F.R. §412.4).

For the reasons stated above, CMS' justification for the very SSO IPPS option, namely to discourage LTCHs from admitting cases that are "premature" ACH discharges, is unsubstantiated and, most often, demonstrably incorrect. As noted above, MedPAC data[14] showing that admission to an LTCH reduces the chance that a patient will be readmitted to an ACH by 26% further undermines CMS' justification that LTCH SSO cases are "premature" discharges from an ACH to an LTCH. Moreover, CMS' premise also is shown to be faulty by the myriad cases where patients admitted from ACHs are discharged from LTCHs to their home or to a nursing home.

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

As discussed in relation to the proposed 25% rule, CMS' proposed reimbursement policy would serve, essentially, as an admission criterion. NALTH reiterates that the question of

[14] *See* MedPAC's June 2004 Report to Congress, Chapter 5 ("Defining Long-Term Care Hospitals") at p. 127.

whether a discharge from any hospital is not medically necessary is a fact-specific medical question, unique to each affected Medicare beneficiary. This question may not be answered by a categorical, unsubstantiated assertion that short-stay cases should have remained in an ACH. CMS has no statutory authority to second-guess the medical judgments of beneficiaries' attending physicians through a reimbursement proposal. QIOs, on the other hand, are enabled by Congress to review physicians' "medical necessity" decisions. The QIO issues final determinations and its review is binding on the Medicare program. *See* 42 C.F.R. §476.85. CMS should not interfere with QIOs' authority. It may, however, increase the scope of QIOs' role by requiring them to review LTCH admissions more extensively. QIOs are required to establish written criteria based on typical patterns of practice in the QIO area or to use national criteria, where appropriate. *See* 42 C.F.R. §476.100(c). *See* Part VIII. of these comments, below, which discusses MedPAC's suggestion that CMS establish patient-level and facility-level criteria to define an LTCH. QIOs could implement such criteria, once they are established.

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

The Medicare program should not establish a *per se* rule which conclusively presumes that any case discharged prior to staying as long as the IPPS ALOS plus one standard deviation for the applicable DRG is a case that should have remained in the ACH. Such a *per se* dictate is flawed not only because, as aforementioned, the dictate cannot be justified factually or medically but also because it undermines the freedom of choice that the Medicare program consistently has recognized as a beneficiary entitlement. *See* Section 1802(a) of the Social Security Act (42 U.S.C. 1395a(a)) and the CMS Publication "Medicare & You: 2007" at p. 25. The idea that patients who qualify for medically necessary LTCH services may be forced to remain for treatment in an ACH setting cannot be reconciled with patients' freedom of choice entitlement.

IV. The Proposed Increase in the HCO Threshold Amount.

As a result of the proposed expansion of the 25% rule and of the very SSO policy under consideration, so much money would be taken out of the LTCH-PPS that the cost threshold for treating longer-term, HCO patients would be increased from $14,887 to $18,774. 72 *Fed. Reg.* at 4800. It is ironic that when CMS attempts to eliminate what it perceives to be inappropriate and short stay patients at LTCHs, it has the unintended consequence of harming payments to the hospitals for those patients who are acknowledged to be long-stay, high cost patients, by raising the HCO threshold.

V. All Elements of the LTCH-PPS Should Be Published Once Per Year, in the Annual LTCH-PPS Update Rule.

NALTH requests that the Secretary revise the time period during which she engages in routine rule-making to make adjustments to the LTCH-PPS. Currently, the Secretary engages in a semiannual rule-making process. An LTCH-PPS update regulation is proposed in February and becomes effective on July 1. An IPPS update regulation is proposed in April or May and becomes effective on October 1. The latter rule-making revises LTC-DRG weights and makes

additional changes to LTC-DRGs. Both of these annual rule-makings often include additional policy changes.

> This dual rule-making process has resulted in instability in LTCHs' budget and planning processes. LTCHs are the only Medicare provider type which is subject to a double rule-making process to establish a single PPS. This problem is complicated further because the two rule-makings are interrelated. It is not reasonable to expect the provider community to comment on the rationality of a payment level proposed in February when that payment level is subject to change in a second rule-making proposed in April or May later in the same year. How is an LTCH to estimate outliers in July if weights will change in October? Accordingly, NALTH requests that, commencing with FY 2009, routine annual adjustments to the LTCH-PPS occur once per year, as is the case for all other provider types. NALTH suggests that the single rule-making occur on the same schedule as that used for the IPPS hospitals, in order to maintain the current cycle for the establishment of LTCH-PPS weights. NALTH further suggests that, in the first year only (*i.e.*, 2009), CMS establish a three-month (from July to September) and a twelve-month (from October to September) update factor.

VI. Research Triangle Institute Findings.

Under its contract with CMS, RTI's purpose is to evaluate and determine the feasibility of actuating MedPAC's June 2004 recommendations to Congress about establishing facility- and patient-level criteria and expanding QIO monitoring. In its Phase I Report (February 2005), RTI reviewed and summarized existing information and analyses about LTCHs' current role in the Medicare system (including their history, the types of patients they serve, existing QIO criteria regarding the appropriateness of care and regulations). RTI used prior analyses and included discussions with MedPAC, other researchers, CMS, QIOs and hospital associations.

In its Phase II Report (October 2006), RTI collected additional information on tools currently used by QIOs and the industry to assess the appropriateness of LTCH admissions. Among other things, RTI: (i) analyzed claims to understand the differences between populations with outlier stays in ACHs and those treated in LTCHs; (ii) visited different types of hospitals to hear how LTCH patients differ from those in other settings and how patterns vary in different parts of the country (including some areas with no LTCHs); and, (iii) worked with NALTH, ALTHA, AHA and AMPRA, as well as several large LTCH chains. The Phase II Report made:

- Patient-Level Recommendations – Including developing admission criteria and restricting LTCH admissions to cases that are medically complex and meet certain medical conditions (*i.e.*, primary diagnosis not rehabilitation or psychiatric).

- Facility-Level Recommendations – Including standardizing Conditions of Participation and setting staffing requirements to ensure appropriate staff for treating medically complex cases.

- Administrative Recommendations - Including clarifying QIOs' roles in overseeing the appropriateness of admissions to LTCHs and allowing them to implement admission and continued-stay criteria.

According to RTI, a future, Phase III Report, will include an examination of the discharge transitions from ACHs in areas that do not have LTCHs (in an attempt to understand any overlap between ACH and LTCH admissions). It also will include a review of proposed and existing criteria[15], patient assessment models used by QIOs and LTCHs, and input from clinicians (with the objective of developing recommendations to CMS regarding patient assessment items for LTCHs).

RTI's recommendations are in line with MedPAC's June 2004 recommendations to Congress. They require the development of facility- and patient-level criteria as a means, essentially, to redefine LTCHs and address concerns about appropriate payment for the services they render. RTI leaves questions of medical necessity (which depend upon the specific facts of a given case) to QIOs, in which Congress has placed this review power, rather than with CMS, which has no such authority.

NALTH contends that many aspects of CMS' proposed rule-making, such as the proposed expansion of the 25% rule and the very SSO policy under consideration, counter Congress' intention that payment concerns should be addressed through the implementation of facility- and patient-level criteria. Rather than waiting for RTI to finish its work, and rather than considering criteria developed by NALTH or others to measure severity for hospital admissions, CMS is proposing to implement harsh regulatory measures, which put the LTCH industry (and the Medicare beneficiaries whom LTCHs serve) at risk.

VII. One-Time Adjustment Scheduled for July 1, 2008.

NALTH believes that, when CMS makes the one-time adjustment to the LTCH-PPS rates under 42 C.F.R. §412.523(d)(3), to be implemented on July 1, 2008, CMS should consider and credit all non-budget neutral adjustments (such as to LTC-DRG weights) which have been made in previous rule-makings. We understand that CMS has agreed to net out ongoing CMI and wage index budget neutrality adjustments with the one-time budget neutrality adjustment when and if this ever is recommended.

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[15] In response to MedPAC's recommendations to Congress, NALTH developed criteria to present to CMS as a means of redefining LTCHs and ensuring proper admissions. After beta-testing and soliciting comments from LTCH organizations and QIOs, NALTH sent the revised criteria to MassPRO for editing and critical review. NALTH reviewed all comments before making a final criteria set and submitting them to MassPRO for validation. In March, 2006, MassPRO testified before the Committee on Ways & Means Subcommittee on Health that it was validating NALTH's criteria. MassPRO reported that the criteria were user-friendly and appropriate for discerning LTCH patients. NALTH has copyrighted these criteria and has (and will) provide them, under a license, to NALTH members, non-member hospitals and hospital chains, and QIOs. These criteria are available to CMS for its consideration as a means of implementing MedPAC's 2004 recommendations to Congress.

VIII. Recommendations.

For all the reason stated in this comment letter NALTH recommends as follows:

- CMS should revise its short stay policy to reflect only cases that are true short stay statistical outliers. For instance, CMS could use percentiles as thresholds that are based on the LTCH LOS distributions by DRG. Lewin has provided two simulations for this, showing that the current law's threshold is not statistically justifiable. If CMS is going to use LOS as the only criteria for selected outliers, it logically should choose a threshold that better isolates cases that are dissimilar to the median and/or average case. For instance, the 5th percentile through 10th percentile, from a statistical perspective, better reflect the concept of outliers. The NPRM sets out payments that reflect about the 37th percentile paying at the NPRM's blend amounts and about the 42nd percentile paying at cost.

- There is good reason for deaths to be eliminated from the short stay policy and be given a full LTC-DRG-based PPS payment. It is difficult for hospitals to predict when patients will die, end-of-life care can be very costly and resource intensive and ACHs are paid a full DRG-PPS payment, so LTCHs should be paid a full LTC-DRG payment as well.

- Patients who exhaust Medicare coverage and remain in an LTCH as well as patients who were admitted to an LTCH from a location other than an ACH, should be excluded from the SSO policy.

- CMS should recognize the fact that SSO rules have the illogical result that many cases defined as SSOs under the policy have lengths of stay approximately the same level as the overall length of stay defining LTCHs – 25 days. How can a stay reflecting the legislated length of stay of 25 days for LTCHs legitimately be defined as SSOs?

- CMS should adopt additional exceptions to the 25% policy for hospitals in rural areas as well as consider a low-volume adjustment similar to that which exists for ACHs under IPPS. Lewin's analysis reveals that smaller hospitals tend to be at greater risk for financially detrimental effects due to the SSO and particularly the 25 percent policy policies.

- CMS should postpone the expansion of the 25% rule to freestanding LTCHs (including grandfathered hospitals) and institute a standstill with regard to the phase-in of the 25% rule for HwHs subject to the current phase-in of percentage thresholds. There are absolutely no data to support the percentage threshold embodied in the 25% rule as a basis to presume any patient is "prematurely" admitted to an LTCH. Additionally, there presently are no data to gage the behavioral changes by LTCHs in response to the current rule and whether or not these changes align with the intended objectives of the policy. Alternatively, in light of the high risk (*i.e.*, that the 25% rule

could result in the denial of medically necessary care), CMS might only apply the 25% rule to those cases that have the same DRG between the ACH and LTCH. We calculate this to be about 20% of the current 25% rule cases. Lewin Report, p. 36.

- CMS should not extend the 25% rule to grandfathered LTCHs.

- If, notwithstanding our comments, CMS does decide to continue implementing the current 25% rule, it should do so only for hospitals, whether they are HwHs or freestanding, that were on notice of the existence of the 25% rule policy (at least for HwHs) prior to the hospitals' seeking of their original certifications as LTCHs. This would exclude all LTCHs established on or before October 1, 2005 (in order to allow for hospitals under development).

- If, notwithstanding our comments, CMS does decide to continue implementing the current 25% rule (and or to adopt the proposed extension of the 25% rule), CMS should investigate ways of limiting cases impacted by the 25% policy to those that are a continuation of the same episode of care started in the IPPS hospital. NALTH simulated the impact of one crude approach to doing this, which involved limiting the 25% policy to those cases that have the same DRG between the ACH and LTCH. NALTH calculate this to be approximately 20% of the current 25% policy cases.

- CMS should clarify the special treatment for urban single or MSA dominant hospitals is applicable on a Core Based Statistical Area [CBSA] bases and is not limited to MSAs.

- CMS should exempt LTCHs in a CBSA from the 25% rule where there is only a single or few (e.g. three) LTCHs, including HwHs within a CBSA.

- CMS should intensify the review of the medical necessity of patients admitted to LTCHs and institute the review of the medical necessity of the continued stay of Medicare patients. This recommendation builds on RTI's finding that some LTCHs may admit acutely ill patients who do not remain at a hospital level of care shortly after admission. RTI indicated that some LTCHs may be retaining these patients as a way to meet the 25-day Medicare ALOS obligation of LTCHs. Under this recommendation, where an LTCH did not correctly identify these patients and institute a search for a lower level of care placement, the related patient days would not be counted toward the 25-day ALOS and payment would be adjusted if the count of medically necessary days would result in a short-stay payment. This recommendation is intended to offer a patient-centered alternative to both the expansion and continued implementation of the 25% rule.

- CMS should develop patient-level criteria that explicitly identify cases that CMS wants treated in LTCHs. The main intention of this recommendation is to replace the 25% rule and SSO policies with these criteria. Even though these policies may reduce Medicare costs, there is no reason to believe that these policies solely target

cases that are inappropriate for LTCH treatment. It is likely that properly defined and implemented patient-level criteria would do a better job in attaining all of the objectives CMS strives for with the 25% rule and SSO policies, without the detrimental effects of increasing the complexity of the LTCH-PPS and reducing care options for its beneficiaries.

- LTCH payments never should be based on acute care payments. LTCHs provide a different type of care in comparison to acute care hospitals leading to different levels of intensity, resources and costs across the two types of facilities.

CMS should have only one annual rule-making for LTCHs as is the case with all other Medicare provider types.

Thank you for the opportunity to submit these comments. We would be pleased to provide any further information you may request.

Sincerely,

Edward D. Kalman
General Counsel

The Lewin Group

Final Report: Analysis of the Long Term Care Hospital RY 2008 Prospective Payment System Notice of Proposed Rulemaking

Prepared for:

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I. EXECUTIVE SUMMARY

A. Purpose

The Lewin Group was commissioned by the National Association of Long Term Hospitals (NALTH), to review and critically appraise the Long Term Care Hospitals RY 2008 Prospective Payment System Notice of Proposed Rulemaking (NPRM)[1]. The Lewin Group scope of work was primarily to simulate and analyze the provisions in the NPRM related to:

- Overall policy considerations and possible policy alternatives
- Revenues
- Margins
- Short stay outlier policies in aggregate and the new very short stay policy approach
- The 25 percent rule, including the expansion to free-standing LTCHs
- Use of averaging
- Overall appropriateness in supporting a viable Long Term Care Hospital (LTCH) industry

B. Overview of Analyses and Key Findings

We started our analyses with the construction of a revenue model which was calibrated to match the impact tables presented in the NPRM.[2] We used the cases from a specially requested patient identifiable 2005 Medicare Provider Analysis and Review (MedPAR)[3] file for the simulation, as well as data from the Centers for Medicare & Medicaid Services (CMS) LTCH impact files for the final rule 2007 rate year (RY) and proposed rule 2008 RY. The patient identifiable file enabled us to track patients from the acute care setting to the LTCH setting, which allowed us to simulate payments following the dictates of the 25 percent rule. We also used additional policy parameters required for payment calculations from the appropriate LTCH and inpatient prospective payment system (IPPS) Federal Registers, such as the high-cost outlier thresholds and the market basket updates. Finally, we use Medicare Cost Report (MCR) data to calculate costs for our aggregate margins.[4]

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[1] FR 72, [CMS-1529-P], February 1, 2007

[2] FR 72, Table 9, p. 4838

[3] CY 2005 MedPAR, December 2006 update

[4] Hospital Cost Report Information System (HCRIS) data, Dec 31, 2006 release.

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1. Revenue Analysis

Beginning in RY 2007 (July 1, 2007), payment for LTCH prospective payment system (LTC-PPS) short stay outliers (SSO) has included a blend of payments based on the LTC-PPS and the acute hospital IPPS. Therefore, both the LTC-PPS and IPPS payment systems need to be included in the revenue models in this project.

The impacts that we estimated for the implementation of the proposed Federal standard rate, wage index, and short-stay outlier policy updates were essentially identical to the estimates CMS reports in the NPRM. These estimates compare payments to LTCHs under the RY 2007 policies versus the proposed RY 2008 policies. We show an aggregate decline of approximately -0.72 percent (***Appendix 1c***), which results from the -0.43 percent impact of the proposed wage index (***Appendix 1b***) and -1.05 percent impact from the proposed SSO policy (***Appendix 1c***) more than offsetting the 0.76 percent increase from the proposed increase to the standard rate (***Appendix 1a***).

Including the current-law and proposed expansion of the 25 percent policy, as well as the proposed payment updates,[5] increases the aggregate decline to approximately -4.0 percent for the average payment amount (See ***Appendix 1d)***. This estimate slightly overstates the impact that the 25 percent rule will have on LTCHs for RY 2008, but we believe it is a truer representation of the impact of the 25 percent rule when compared to the CMS estimate, which does not account for the change in the applicable threshold in RY 2008 for co-located LTCHs.

2. Margin Analysis

We constructed a margin model that matches our estimated revenues with costs estimated from the Medicare Cost Reports. We also provide margins on an overall and type of hospital basis (see ***Exhibit II.B-2a***). We predict an overall margin of –0.84 percent for RY 2008 after including all of the RY 2008 NPRM with the exception of the 25 percent rule. This is down from 0.01 to 1.9 percent, estimated by MedPAC[6] and 2.87 percent as estimated by Lewin for 2007. ***Exhibit II.B-2b*** shows overall margins including the impact of the 25 percent policy, which is estimated to be –4.31 percent. This estimate is well below the 4 to 6 percent positive margin generally thought to be required to support hospital modernization and refurbishment and allow the hospital to keep current with emerging technologies.

When analyzing the revenue and margin data by the different hospital types, evidence was reviewed for possible inequities across geographic locations, with rural and other urban hospitals seemingly harder hit by the SSO and the 25 percent policy compared to hospitals in large urban areas (***Exhibits II.B-2a*** and ***II.B-2b***). LTCHs in areas with fewer hospitals may be forced to take on a greater percentage of cases from a single source and hence be more detrimentally impacted by the 25 percent rule. This may be an indication that the provisions

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[5] Standard Amount, Max Loss Threshold, Area Wage Adjustment, SSO Approach

[6] MedPAC, March 2007. *Report to Congress: Medicare Payment Policy.*

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CMS included with the 25 percent rule to protect hospitals in areas with few providers may not suffice.

3. The Short-Stay Outlier Policy Analysis

We next investigated the impact of short-stay outlier payments before including the effects of the 25 percent rule. We focused on the proposed changes to the way these cases are paid. The proposed policy does not impact the number of SSO cases identified, but does decrease payments for SSO cases by approximately 6.2 percent (see ***Exhibit II.C.2-1***), which has a -2.2 percent effect on overall Medicare margins (measured as proportion of SSO cases (36.1 percent) x -6.2 percent). Approximately 31.0 percent of the SSO cases were simulated to be paid using the new SSO option under the 2008 NPRM. These are SSO cases having a length-of-stay (LOS) less than the average LOS experienced in IPPS hospitals plus one standard deviation for the same diagnosis related groups (DRG). For these cases, the proposed SSO policy decreases payments by nearly 24 percent having a -2.6 percent effect on overall Medicare margins. Note that since the new option by definition has a shorter LOS than the other SSO cases, we refer to this option as the very-short stay outlier (VSSO) option throughout this report.

Because the SSO and 25 percent policy are centered on the notion that certain cases being treated in LTCHs may be more appropriately reimbursed under an IPPS system, we analyzed the resources used for LTCH and IPPS stays. We find that LTC-SSO visits for the same DRG last over 70 percent as long and cost about 46 percent more in comparison to visits in the IPPS setting (see ***Appendix 3***), indicating that these are not the same kind of treatment experiences. The high cost of providing care to LTCH patients coupled with the reduced payments under the SSO policies leads to a significant reduction in margins. The negative impact of the proposed LTC-PPS payment rates for SSOs would result in nearly 60 percent of LTCHs having negative Medicare LTC-PPS margins with an overall Medicare LTC-PPS margin of about -0.84 percent (see ***Exhibit II.B-2a***). These findings make the application of an IPPS payment methodology to LTC-PPS SSO cases seem inappropriate.

One of the more important findings of the analysis is the high number of LTCH SSO cases ending in deaths. Approximately 23.7 percent of all SSO cases end in death with 37.8 percent under the very SSO cases (see ***Exhibits II.C.3-2 and II.C.4-1***). We estimate an equivalent rate of about 4.3 percent for IPPS hospitals (see ***Exhibit II.C.4-1***). Many studies have shown that end-of-life care tends to be very expensive, so we consider this to be evidence that the level of care for SSO cases where the patient dies is in general much more intensive compared to the typical IPPS case.[7] In summary, we believe that the NPRM proceeds as if nearly all SSO cases are inappropriately placed. Our analyses indicate that this is not reflective of the actual resource use for SSO cases.

[7] "Medicare and End-of-Life Care", M. Moon and C. Boccuti, the Urban Institute, 2002 and "Financing End-of-Life Care: Challenges for an aging population", Changes In Health Care Financing & Organization, Academy Health, February 2002.

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4. The 25 Percent Rule Analysis

Expanding the 25 percent rule to free-standing hospitals is similar in several respects to the proposed changes to the SSO policy. First, each policy does not seem clinically justifiable. Second, each policy makes changes to a previous policy that has not yet been fully tested and understood through data analyses. Third, the objective of each policy may be better served with a more direct approach such as patient and facility criteria explicitly aimed at insuring that only appropriate cases are admitted to LTCHs. Otherwise, these misguided policies inadvertently punish LTCHs and Medicare enrollees needing LTCH services.

C. Summary

The LTC-PPS is moving further away from a prospective payment system. Nearly half of all LTC-PPS cases are not paid on a DRG PPS basis. That is, approximately 50 percent of all cases in our simulated database were paid under a high cost outlier (HCO), short-stay outlier (SSO), or 25 percent rule basis. In fact, according to our simulated RY 2008 database, over 20 percent of all LTCH cases will be paid at least partially under an IPPS basis. The increasing complexity to the LTC-PPS takes away from the advantages of having a prospective payment system. The 25 percent rule will involve retroactive payments, which will make it difficult for hospital administrators to plan financial operations accordingly, particularly since margins for these cases will be very low.

Given our findings, we conclude that CMS should reconsider the methodology and proposed payment rates outlined for LTCHs in the NPRM:

- Exclude from the SSO policy cases resulting in death. These cases do not seem to adhere to the objective of the SSO policy, which is to insure that LTCHs are treating patients that should be treated in LTCH facilities. The inclusion of deaths in the SSO policy is problematic and undermines the integrity of the LTC-PPS. These cases are difficult for LTCHs to predict and end-of-life care is associated with very high intensity and resource use.[8]

- Similarly, SSO cases that result from patients exhausting their Medicare coverage should be excluded from the SSO policy, because these are not really short-stay cases (i.e. they continue their stay after the date of exhaustion). These SSO cases could result in significant underpayments to LTCHs when they admit very ill patients who have a long length of stay but who exhaust their limited Medicare day benefit prior to reaching SSO threshold points.

- CMS may want to consider thresholds for the SSO policy that better identify "outliers" and cases that are similar to IPPS cases. CMS contends that short stays in LTCHs are similar to IPPS cases. The thresholds for defining short stays is equal to 5/6 the geometric mean LOS for all LTCH cases for the particular DRG. In this rule,

[8] Ibid.

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CMS now proposes to adopt another threshold that is supposed to identify LTCH cases that are similar to IPPS cases. CMS may consider replacing the 5/6 threshold, which is clinically arbitrary and empirically illogical for selecting "outliers" under a prospective payment system and use the proposed very short-stay outlier threshold, which is at least theoretically a better match for the objective. In most cases, using the very short stay outlier threshold would be a more appropriate statistical measure of an outlier as it identifies cases that are less like the median and at the same time more extreme.

- Alternatively, CMS could consider thresholds based upon the distribution of LTCH cases and should only apply the SSO policy to the cases at the extreme ends of the distribution. (e.g. the 5th and perhaps 10th percentile).

- Payment should not be based on IPPS levels as they are not reflective of LTCH costs.

- Develop patient criteria (based on MedPAC recommendations) that explicitly identify cases that CMS does not want treated in LTCHs.

- Because of the high detrimental risk to Medicare enrollees, as well as providers, CMS should not expand its 25 percent policy and should not adopt the proposed SSO policy.

- Our analysis reveals that smaller hospitals tend to be at greater risk for financially detrimental effects due to the SSO rule and particularly the 25 percent policy. CMS should consider additional exceptions to the 25 percent rule for hospitals in rural areas as well as a low-volume adjustment similar to existing policy for acute care hospitals under IPPS.

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II. RESULTS AND METHODS

A. Revenue Analysis

We calculated LTC-PPS revenue by applying the proposed payment rules for 2008 in the NPRM[9] to the actual discharge-level data in the 2005 MedPAR file. [10] We also applied the 2007 current law to these same data, and calculated the change in revenue that would occur from the 2007 rules to the proposed 2008 rules. This allows us to compare payments to LTCHs under the rate year 2007 policies versus the proposed 2008 policies.

We estimated revenues based on provider characteristics from the impact file[11], and discharges in the 2005 MedPAR file. For each hospital, we calculated the adjusted Federal standard rate based on the labor share of costs, and the regional wage index and cost-of-living adjustment (COLA) factor for that particular hospital. Then, for each discharge, we calculated the LTC-PPS DRG payment, taking into account the various payment methods, including short-stay and the high-cost outlier payments. For purposes of high-cost outlier (HCO) payments, we calculated case costs based on Medicare covered charges as reported in MedPAR, which were inflated from 2005 to 2008 by the annual market basket rate of increase[12], multiplied by the hospital's cost-to-charge ratio as reported in the impact file.

When calculating 2008 revenues, we calculated short-stay outlier (SSO) payments according to the newly proposed rule, by taking the lowest of:

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

(2) **Per Diem**: The per-diem payment based on the number of days of the stay; that is, the adjusted federal LTC-PPS DRG rate, divided by the geometric mean length of stay for that LTC-DRG, multiplied by the number of covered days and a short-stay factor of 1.2

(3) **Full LTCH DRG**: The full LTC-DRG payment amount.

(4) **Blended Rate**: A blend of the per diem amount and the payment that the hospital would have received under the IPPS, taking into account the Medicare wage index, COLA, geographic adjustments, Medicaid Disproportionate Share Hospital (DSH) adjustment, and medical education adjustments.

(5) **"Comparable" Full IPPS**: For cases below the IPPS average LOS plus one standard deviation for the same DRG the "Blend Option" is replaced by a comparable IPPS payment amount. For these cases, the payment cannot exceed the comparable IPPS payment amount.

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[9] FR 72,[CMS-1529-P] February 1, 2007

[10] CY 2005 MedPAR, December 2006 update

[11] FR72, [CMS-1529-P] Impact Data File at cms.hhs.gov\longtermcarehospitalpps\ltchppsrn

[12] Available at http://www.cms.hhs.gov/MedicareProgramRatesStats/downloads/ marketbasketdnld.zip

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Our revenue results are presented overall and by type of hospital. As with the NPRM, we show an aggregate decline of approximately -0.72 percent (***Appendix 1c***), which results from the -0.43 percent impact of the proposed wage index (***Appendix 1b***) and -1.05 percent impact from the proposed SSO policy (***Appendix 1c***) more than offsetting the 0.76 percent increase from the proposed increase to the standard rate (***Appendix 1a***). CMS reports similar impacts of 0.6, -0.5, -0.9 and -0.7 percent for the proposed Federal standard rate, wage index, SSO policy and aggregate impacts respectively.[13]

Exhibit II.A-1 summarizes our results on a cumulatively incremental basis. The cumulative impact, up to and including the SSO policy, is relatively small across hospital categories, except for rural hospitals which lose 2.6 percent.

Exhibit II.A-1. Incremental Cumulative Percentage Impact in RY2007 Payment to Proposed RY2008 Payment

LTCH Classification		Number of LTCHs[1]	Number of LTCH Cases[2]	Impact of Standard Amount[3]	Impact of Area Wage Adjustment[4]	Impact of Very SSO Approach[5]	Impact of Expanded 25% Rule
All Providers		369	130,599	0.8%	0.3%	-0.7%	-4.0%
By Location							
	Large Urban	181	78,026	0.8%	0.8%	-0.2%	-3.0%
	Other Urban	163	47,307	0.7%	-0.4%	-1.5%	-5.7%
	Rural	25	5,266	0.5%	-1.5%	-2.6%	-5.9%
By Ownership / Control							
	Voluntary	122	38,806	0.7%	0.1%	-1.0%	-5.5%
	Proprietary	232	86,387	0.8%	0.4%	-0.6%	-3.5%
	Government	15	5,406	0.8%	0.3%	-0.5%	-1.9%
By Region							
	Midwest	84	24,073	0.8%	0.7%	-0.4%	-3.3%
	Northeast	42	17,810	0.9%	0.7%	-0.1%	-4.1%
	South	205	73,823	0.7%	-0.4%	-1.5%	-5.3%
	West	38	14,893	0.9%	2.2%	1.2%	0.0%
By Bed Size							
	1: 1-24	41	7,683	0.7%	-0.1%	-1.3%	-5.4%
	2: 25-49	197	51,891	0.8%	0.1%	-1.1%	-6.2%
	3: 50-74	57	23,132	0.7%	0.3%	-0.9%	-2.5%
	4: 75-124	42	23,800	0.8%	0.5%	-0.5%	-2.4%
	5: 125-199	18	12,379	0.7%	0.6%	-0.2%	-2.9%
	6: 200 - 299	10	7,799	0.8%	1.6%	0.9%	-1.3%
	7: 300+	4	3,915	0.9%	1.2%	0.7%	0.3%

[1]CMS-1529-P LTCH Impact file and March 2006 Provider of Services data

[2]December 2006 update of FY2005 MedPAR

[3]CMS estimates that the update to the standard amounts in isolation of the area wage adjustment under current law with the SSO policy which includes "IPPS comparable payments" on average would increase payments to LTCHs by 0.66%.

[4]CMS indicates that in absence of the SSO approach, all LTCHs, on average, would experience a 0.3 percent increase in estimated payments from the RY2007 LTCH PPS to the RY2008 LTCH PPS for all proposed payment rate and policy changes presented in the preamble of the proposed rule (72 FR 4839).

[5]CMS indicates that all LTCHs, on average, would experience a -0.7 percent decrease in estimated payments from the RY2007 LTCH PPS to the RY2008 LTCH PPS for all proposed payment rate and policy changes presented in the preamble of the proposed rule (72 FR 4839) inclusive of the SSO approach for very short stay outliers.

Source: Lewin Group analysis of Proposed RY 2008 LTC-PPS payment update

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[13] FR 72, Table 9, p.4838

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Including the current-law and the proposed expansion of the 25 percent policy increases the aggregate decline to approximately -4.0 percent for the average payment amounts (See ***Appendix 1d)***.

In the NPRM, CMS reports an estimated impact of -2.9 percent when including the expansion to the 25 percent policy to grandfathered and free standing LTCHs in their simulation.[14] However, they do not simulate the impact of the current-law 25 percent policy which affects co-located LTCHs (i.e. hospital-within-hospitals (HwHs) and satellites). The -4.0 percent that we report reflects the impact on both the hospitals impacted by the RY 2008 proposed expansion to the 25 percent policy (i.e. free-standing and grandfathered LTCHs) and the current-law RY 2007 25 percent policy, which only pertains to co-located hospitals. For this reason our measured impact is greater. When we isolate the impact of the expansion to the policy, we measure a decrease of 1.7 percent to the average LTCH payment for RY 2008. This is similar to the 2.2 percent decrease that CMS reports as the impact solely applicable to the expansion of the 25 percent policy. We are using a different version of the MedPAR and an updated list of LTCH co-located hospitals[15], so we would expect some discrepancy between Lewin calculations and those published by CMS in the NPRM.

We feel that it is important to report the final RY 2008 impact inclusive of the full impact of the 25 percent policy, because it will be more reflective of the 2008 payment environment. Also, in RY 2007, the 25 percent policy is not fully phased in, so there will be a nontrivial impact to even the co-located hospitals in RY 2008. In other words, it is not correct to assume that the 25 percent policy impacts co-located hospitals in the same manner in RY 2007 and RY 2008. In fact, the Office of the Actuary at CMS has estimated the impact for co-located hospitals of the 50 percent or applicable threshold in RY 2007 to be only one-quarter of the impact due to the 25 percent or applicable threshold in RY 2008.[16] Thus, while our -4.0 percent may be overstated, we expect the CMS estimate of -2.9 to be understated by a relatively greater amount.

B. Margin Analysis

We estimated the cost per Medicare patient day for each LTCH by taking its Medicare costs as reported in its Medicare cost report (MCR) [17], divided by the number of Medicare patient days reported in the MCR, and inflating the resulting cost per day to 2007 and 2008 using the estimated price index from the 3Q06 release of the Rehabilitation, Psychiatric and Long Term Care (RPL) market basket file.[18] For each discharge in the 2005 MedPAR file, we multiplied the number of Medicare covered days by the cost per day to estimate the cost for that discharge. While this does not account for the cost differences in treating patients with different DRGs for the same number of days, it is appropriate for costs aggregated at the level of the hospital (or hospital group).

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[14] FR 72, p. 4844
[15] List of co-located hospitals obtained from CMS, February 2007.
[16] CBO scoring letter prepared by Lewin for NALTH, March 5, 2007.
[17] HCRIS, Dec 31, 2006 release.
[18] Available at http://www.cms.hhs.gov/MedicareProgramRatesStats/downloads/ marketbasketdnld.zip

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We calculated Medicare margins for LTCHs under the proposed rule, as shown in ***Exhibit II.B-2a.*** The aggregate Medicare LTC-PPS margin is estimated at –0.84 percent for RY 2008, down from 2.87 percent in RY 2007. The percentage of LTCHs with negative margins (i.e. a margin less than zero) increases to 59.5 percent for RY 2008, up from 46.2 percent for RY 2007, which further illustrates the restrictive nature of the proposed RY 2008 LTC-PPS.

Exhibits II.B-2a. Simulated Medicare Margins in Aggregate and for Hospital Types: RY 2007 and RY 2008

LTCH Classification	Number of LTCHs[1]	Number of LTCH Cases[2]	RY2007					RY2008 w/ SSO				
			Average margin	Percent Negative	Percentile 25th	50th	75th	Average margin	Percent Negative	Percentile 25th	50th	75th
All Providers	369	130,599	2.87%	46.2%	-6.7%	1.5%	10.0%	-0.84%	59.5%	-12.4%	-2.5%	6.7%
By Location												
Large Urban	181	78,026	4.13%	40.9%	-3.9%	2.9%	12.4%	1.01%	50.8%	-8.3%	-0.1%	9.4%
Other Urban	163	47,307	1.05%	49.1%	-9.1%	0.8%	8.5%	-3.57%	66.3%	-14.8%	-4.1%	3.7%
Rural	25	5,266	-1.83%	66.7%	-16.3%	-1.8%	4.6%	-7.74%	79.2%	-24.8%	-7.0%	-1.2%
By Ownership / Control												
Voluntary	122	38,806	1.71%	54.9%	-10.0%	-1.2%	8.4%	-2.36%	65.6%	-15.1%	-4.7%	3.9%
Proprietary	232	86,387	3.70%	41.1%	-5.8%	2.8%	10.3%	0.14%	56.3%	-9.9%	-1.2%	7.6%
Government	15	5,406	-2.41%	53.3%	-37.8%	-2.8%	13.8%	-6.06%	60.0%	-41.9%	-8.3%	12.4%
By Region												
Midwest	84	24,073	6.65%	35.7%	-4.2%	4.4%	12.4%	3.41%	46.4%	-9.5%	1.2%	9.7%
Northeast	42	17,810	7.26%	29.3%	-0.3%	9.3%	13.8%	4.27%	41.5%	-4.0%	6.2%	10.4%
South	205	73,823	-0.26%	55.6%	-11.4%	-1.8%	6.5%	-4.90%	71.2%	-16.9%	-6.8%	2.4%
West	38	14,893	5.23%	36.8%	-2.1%	5.5%	9.7%	3.42%	44.7%	-4.7%	3.0%	8.0%
By Bed Size												
1: 1-24	41	7,683	0.30%	68.3%	-15.2%	-4.3%	4.9%	-4.13%	75.6%	-22.1%	-8.8%	0.9%
2: 25-49	197	51,891	3.47%	39.3%	-6.2%	3.5%	10.2%	-0.63%	54.6%	-12.2%	-0.7%	6.6%
3: 50-74	57	23,132	1.03%	52.6%	-7.9%	-0.6%	6.5%	-2.96%	68.4%	-13.7%	-4.3%	2.2%
4: 75-124	42	23,800	2.86%	50.0%	-6.0%	-0.1%	10.1%	-0.60%	61.9%	-10.1%	-3.8%	8.0%
5: 125-199	18	12,379	3.63%	55.6%	-3.9%	-0.3%	12.2%	0.48%	61.1%	-8.1%	-4.2%	9.5%
6: 200 - 299	10	7,799	1.95%	40.0%	-2.0%	3.3%	13.8%	-0.20%	50.0%	-4.4%	-0.1%	13.1%
7: 300+	4	3,915	10.90%	0.0%	8.4%	12.7%	31.2%	8.75%	0.0%	5.1%	10.6%	30.6%

Exhibit II.B-2b shows the overall margin, including the impact of the 25 percent policy, to be –4.31 percent. This estimate is well below the 4 to 6 percent positive margin generally thought to be required to support hospital modernization and refurbishment and allow the hospital to keep current with emerging technologies. In fact, hospitals may not be able to operate if they are subject to continuous negative margins and related cash flow.

Similar to the SSO policy, we note that the detrimental impact that the 25 percent policy has on margins for other urban and rural LTCHs seems to be relatively greater in comparison to large urban hospitals. This may be reflective of the market differences between areas with more hospitals (i.e. urban hospitals) versus those with fewer hospitals (i.e. other urban and rural hospitals). The areas with fewer LTCHs may be forced to take on a greater percentage of cases from a single source and hence be more detrimentally impacted by the 25 percent policy. Also, in market areas where there is a single or only few referring sources, it would be more difficult for a LTCH to avoid the 25 percent rule. In these areas it is likely that one of the acute hospital referral sources would treat the most severally ill cases that become appropriate for LTCHs. We included in our simulation of the 25 percent policy the higher threshold amounts for hospitals in single urban and MSA dominant areas, so it is possible that these exceptions to the rule put in place by CMS do not provide enough protection for these hospitals.

Given this, it is not surprising that there is a very high correlation between hospital bed size and margins after we include the impact on payment calculations under the expanded 25 percent policy. Margins are greater than eight percent for LTCHs with more than 300 beds and are

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negative for all LTCHs with less than 300 beds with the margin getting lower as the bed size decreases. This effect may be related to the geographic area phenomenon described in the previous paragraph. It is also noteworthy that none of the four hospitals with over 300 beds are estimated to have negative margins.

Exhibits II.B-2b. Simulated Medicare Margins including the impact of the 25 percent policy in Aggregate and for Hospital Types: RY 2007 and RY 2008

LTCH Classification	Number of LTCHs[1]	Number of LTCH Cases[2]	RY2008 w/ 25% Rule				
			Average margin	Percent Negative	Percentile		
					25th	50th	75th
All Providers	369	130,599	-4.31%	59.51%	-18.65%	-6.24%	2.96%
By Location							
Large Urban	181	78,026	-1.85%	50.83%	-12.41%	-3.91%	6.70%
Other Urban	163	47,307	-8.18%	66.26%	-22.15%	-10.42%	0.24%
Rural	25	5,266	-11.53%	79.17%	-24.75%	-12.97%	-2.32%
By Ownership / Control							
Voluntary	122	38,806	-7.19%	65.57%	-23.83%	-10.21%	0.30%
Proprietary	232	86,387	-2.85%	56.28%	-16.26%	-4.19%	3.79%
Government	15	5,406	-7.59%	60.00%	-41.86%	-12.11%	12.39%
By Region							
Midwest	84	24,073	0.48%	46.43%	-16.54%	-3.40%	6.74%
Northeast	42	17,810	0.33%	41.46%	-10.94%	-0.09%	8.05%
South	205	73,823	-9.16%	71.22%	-24.75%	-10.87%	-1.75%
West	38	14,893	2.34%	44.74%	-6.24%	-1.23%	7.47%
By Bed Size							
1: 1-24	41	7,683	-8.64%	75.61%	-31.79%	-14.42%	-2.40%
2: 25-49	197	51,891	-6.09%	54.59%	-18.99%	-7.33%	2.96%
3: 50-74	57	23,132	-4.64%	68.42%	-14.01%	-5.05%	2.05%
4: 75-124	42	23,800	-2.62%	61.90%	-12.11%	-5.13%	6.92%
5: 125-199	18	12,379	-2.33%	61.11%	-13.03%	-7.76%	9.54%
6: 200 - 299	10	7,799	-2.44%	50.00%	-18.44%	-0.13%	13.11%
7: 300+	4	3,915	8.40%	0.00%	5.10%	10.59%	28.43%

Interestingly, there is an IPPS policy developed by CMS to protect acute hospitals with a low volume, as it is harder for them to spread their overhead costs. Perhaps a similar protection should be developed for low-volume LTCHs. This is particularly the case as many LTCHs have case counts low enough possibly making them prone to an adverse random selection of patients in any given year which forces more of their cases to be affected by the significantly lower payments under the 25 percent rule.

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C. Short Stay Outlier Analysis

1. Clinical Analysis of CMS Proposed Revisions to the Short-Stay Outlier Policy

The NPRM's revised short stay outlier rule is in large part predicated "on the belief that many of these patients could have been treated more appropriately in an acute care hospital subject to the acute care hospital inpatient prospective payment system."[19] CMS, by applying "IPPS like" payments to several types of LTCH short stay outlier cases, obviously believes that these IPPS payments are appropriate. In the analysis that follows we first consider the degree to which LTCH short stay cases are clinically comparable in intent and outcome to acute care hospital (ACH) cases across the two settings. Then we review the empirical justification or lack thereof for the SSO policy. These findings are then extended to financial implications for LTCHs.

As MedPAC notes in its March 2007 Report to Congress, "Patients with clinically complex problems, such as multiple acute or chronic conditions, may need hospital-level care for relatively extended periods."[20] The difficulty in predicting which patient discharges fall into this category is well known. In the past several years NALTH has developed patient screening criteria similar to MedPAC's recommendations.

As will be discussed in more detail, the high proportion of deaths in overall short stay outliers at 23.7 percent and the new short stay outliers at 37.8 percent speaks clearly to this point. At minimum these patients reflect severe illness and should be removed from the SSO policy as it is well known that deaths are expensive in the hospital setting. As with the IPPS, these cases could be paid as typical LTC-DRG cases. Aside from deaths the clinical decision to send a patient to an LTCH is typically well considered and not predominately financially motivated as CMS would have us believe.

NALTH and Lewin sponsored a series of conference calls with LTCH physicians and physicians that refer patients to LTCHs. During these conference calls Lewin explored LTCH referral patterns in terms of their timing and how they affect ACH outliers. We wanted to know, from the physicians' point of view, if an ACH's extending its course of treatment is appropriate when the LTCH alternative is available.

The following observations were made during these conference calls. LTCH admitting processes (currently most often guided by admission criteria) can help determine who should go to an LTCH and when. If the LTCH knew in advance that it would be penalized for taking a given patient they would shy away from these referrals. But it is difficult to predict in advance which patients will be short stay (e.g.: deaths or readmissions to ACHs) or long stay. If "early" LTCH admissions reduce LTCH ALOS and resultant short stay payments reduce LTCH margins, patients may be held in the ACH setting when it is not clinically in their best interest. The latter is true to the extent that ACHs do not start therapies which LTCHs often provide if

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[19] 67 FR 55995 as quoted on 72 fr 4804

[20] MedPAC. March 2007. *Report to Congress: Medicare Payment Policy*, p. 223.

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they intervene earlier. The panels' physicians agreed that if patients sit idle and de-condition in the ICU until they get to the LTCH that critical time is lost for whole patient restoration.

LTCH physicians also noted that if patients are transferred from the ACH "too late" they are in worse condition with multiple comorbidities that could have been avoided or have been less serious if the LTCH could have received the patient earlier. If ACHs keep patients long enough to get the full PPS-DRG payment, or a PPS outlier payment, but do not provide any whole patient care while the patient is in the ACH, clinical problems can emerge. For instance infections, ulcers, nutrition, and atrophy of muscles can worsen if ACHs hold patients too long. In the end Medicare may pay more in outlier payments to the ACH than if the patient is transferred to an LTCH in a timely fashion.

The LTCH industry is a provider of specialized care. LTCHs are providing care that is not rendered now – or likely in the future -- in ACHs. CMS does not recognize this basic distinction in its rule making. CMS argues in defense of its short stay policy and 25 percent policy that if admissions to LTCHs are inappropriate, that LTCHs are not providing the complete course of treatment. In this sense CMS contends that LTCHs are acting as step-down units and should not receive the full LTC-PPS DRG payment. However, the NALTH physician panels indicated that LTCHs should not be penalized for doing what they consider to be clinically appropriate for the patient.

The distinction between ACHs and LTCHs is an interpretation of activities: diagnosis focused vs. whole patient recovery. This difference represents two different philosophies of care. To understand why clinical outcomes might vary by setting, the distinctions between ACHs and LTCHs clinical care must be highlighted.

ACHs are diagnosis focused and provide critical care to acutely ill patients. An ACH ICU admits a patient who is severely ill - - typically on a single clinical dimension - -and needs immediate attention focused on a single (or few) diagnosis(es). In an acute care setting, once the patient is stabilized, by design and intent, the ACH moves on to the next critical case. When it comes to the recovery of a complete human being - - cognitively and physically - - the ACHs are not aligned to provide the complete array of team-based services necessary to bring about full recovery. There is no team in place and no funding that will allow ACHs to provide the level of care given in LTCHs. The LTCH team approach is exemplified with a LTCH physician account as follows:

> *"LTCHs are designed to provide an interdisciplinary team approach to care. In our hospital…all disciplines assess the patient upon admission (Nursing, Respiratory Therapy, Pharmacy, Nutrition, Physical Therapy, Occupational Therapy, Speech Therapy, Enterstomal Therapy, Social Work and Case Management) and develop a plan of care, which includes short and long term goals. An example of the interdisciplinary team process can be demonstrated in a current patient who was admitted from ACH CVICU where she had a 56 day LOS. The 73yr old female was admitted to the LTCH with respiratory failure on a ventilator and currently at day 15 she has been weaned from the ventilator and tracheostomy corking trials are in progress. Her daughter is a RN working the ACH CVICU and has been extremely impressed with the team work and progress of her mother.*
>
> *The entire team meets weekly with the medical director to review patient progress toward goals set at admission, discuss problems and develop further goals for treatment. The patient and family is also*

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included in this process as the discussions with patients and family are vital to the recovery of the patient and plans for discharge.

Another example of the complex patient and the accomplishments toward patient goals is seen in the following patient:

A 71 year old male with sacral decubitus, ESRD, confusion, anemia, chronic renal failure and a non healing leg ulcer was finally discharged to a Skilled Nursing Facility after a 108 day stay. The patient was receiving wound care, hemodialyis and had episodic agitation and confusion requiring physical restraints and adjustment of psychiatric medications. At several times during his long stay, attempts were made to discharge the patient to a Skilled Nursing Facility; however the barriers to discharge were his continued need for outpatient hemodialysis and the continued periodic need for restraints. We found no Skilled Nursing Facility agreeable to admit the patient with restraints and an outpatient hemodialysis unit to dialyze patient needing restraints. The interdisciplinary team worked diligently to review and change medication regimes, identify alternatives to using restraints so that finally the patient could be managed on appropriate medication and no restraints thus facilitating the discharge after the 108 day stay."

While the patient to nurse ratio is similar to step down units in ACH, the entire team approach with all disciplines is the key to improved outcomes for the patient. In a LTCH setting there is consistency with all disciplines where in the ACH setting the Respiratory Therapist, Physical Therapist, Occupational Therapist and Speech Therapist often are different from day to day. The interdisciplinary team approach and consistent staff is the valuable commodity to provide the specialized care that LTCHs offer."

The LTCHs focus is on recovery of the whole patient. Fifteen to twenty years ago, before LTCHs, a patient might languish in an ACH ICU 8 to 10 days. Without specialized care the patient would "sink or swim" clinically. For patients who were ventilator dependent for instance, the step-down unit potentially was a lifetime sentence to ventilator dependency. These types of patients require continual vent adjustment, physical therapy, controlled diet and other services in order to recover.

Today, LTCHs often help these same patients recover all functions (both cognitive and physical) and return to the community. LTCHs provide attention to numerous clinical details with an integrated team approach to recovery. An LTCH can provide continual ventilator adjustment, nutrition, physical therapy, and any other skill set necessary to heal the whole patient. In the appropriate setting, team based caregivers can attend to multiple clinical problems.

When the patient is treated by a collection of cross-trained people who can provide acute care, chronic care and rehabilitation, the patient is able to return to home or the community because of the following:

1. The patient's feet touch the ground
2. The patient's head is clear
3. The patient's stomach is able to tolerate nutrition

If not for LTCHs, the most severely ill patients might end up in a skilled nursing facility (SNF) and never regain the level of functional ability they may get from the LTCH. If patients get a secondary infection in a SNF, they may be bounced back to the ACH. This ultimately costs more

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to Medicare and out-of-pocket for the patient as well. In fact, MedPAC estimates that patients using LTCHs were readmitted 26 percent less frequently than similar patients in alternative settings.[21]

If LTCH patients remained in the ICU, ACH length of stay would go up. Currently, those patients transferred to the LTCH could stay longer in the ICU. If the ICU is filled with patients that are better served in LTCHs then the ACH will lose surgical cases because there are no recovery room beds. This works as follows (again, based on physician accounts):

> *"Bed flow and throughput in our hospital's cardiac and medical intensive care units is vital to the operations of the acute care hospital. Our host hospital…is a tertiary acute care hospital,* [and serves the area] *for cardiovascular, neurosurgery, oncology, and orthopedic care. Patients who are more appropriate for the LTCH can be discharged from the ACH and admitted to our hospital so patients who need critical care can be hospitalized in the intensive care units."*
>
> *"It is the belief of many physicians who practice in both acute care and long-term acute care hospitals that early transfer to LTCHs benefits the patients significantly. The reasons vary but the effect is realized over and over in actual patients. Even when the physician team is identical in both settings, patients improve faster and recover more completely when transferred very early after "stabilization" of their acute critical illness.*
>
> *Though the reasons for this observed phenomenon have not been well studied, some common themes include:*
>
> - *Acute care hospitals are designed to stabilize emergent and in many cases immediately life-threatening illnesses. Once accomplished, attention, human resources, and necessity turn to the next unstable, critically ill patient. The staff, time, and teamwork required to concurrently treat and recover a chronic critically ill patient is directed to the next more acutely unstable patient admitted to the hospital.*
> - *As acute care improves, patients who previously succumbed to their illness now survive, but in a gravely impaired condition. The timeline to recovery is lengthy, and the sooner a patient specific long-term treatment plan is implemented, the better and more functional the recovery. Most clinicians believe there is a 'window of opportunity' early on after stabilization when the most progress can be made.*
> - *Critical illnesses are 'coded' by diagnoses, but particularly in the elderly, all systemic diseases affect the entirety of the patient including mental (delirium), neuromuscular (physical debility), cardiopulmonary deconditioning (ability to tolerate even simple physiologic challenges like sitting and walking), nutritionally (limited tolerance to enteral nutrition), and maybe most importantly immunologically (evidenced by the high prevalence of secondary sepsis in protracted ICU care patients). Correcting these issues requires dedicated team approaches, far exceeding the available staff time in an acute care facility.*

[21] MedPAC, June 2004. *Report to Congress: New Approached in Medicare*. <Available as of February 1, 2007 at http://www.medpac.gov/publications/congressional_reports/June04_Entire_Report.pdf>.

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- *Grouping similarly afflicted patients has allowed for the development and maintenance of specialized skills found in LTAC Hospitals. The sooner patients receive this specialized care, the better their outcome."*

A typical patient may present with a history of COPD, hypothyroidism, and mild renal insufficiency. Upon presentation to an acute care emergency department has a ruptured Aortic Aneurysm. After successful surgical stabilization and ICU care, it is clear that due to his COPD, ventilator weaning is not possible and on day 3 or 4, he has a tracheotomy. This patient will require an estimated 30 days to recover and successfully wean from the tracheotomy.

Issues related to successful outcome include adequate nutrition, which is limited by his abdominal surgery and post-op ileus. Assistance with mobilization will require simultaneous care by a nurse capable of dealing with critical care and monitoring, a respiratory therapist to assist with airway safety and ventilation, a physical therapist and an assistant. This one task will be repeated twice daily with adjustments in patient goals and expectations at each attempt.

Dedicated pharmacy care, social worker support, emotional care and physician direction occurs daily. This simply cannot be done in an acute ICU because of the enormous time requirements. Acute care staff is already overburdened with the perpetual arrival of yet another unstable patient."

Under the team approach for systems that include an ACH and an LTCH, the LTCH wants patients transferred as soon as possible so that recovery of the whole patient can commence. This is what LTCHs are set up to do – a specialized type of care. As one physician noted:

"*The sooner a patient can be admitted to the LTCH, the potential for recovery is increased. The focus is on the whole patient and not the disease specific focus, which is necessary in the ACH.*"

In summary LTCHs provide a specialized hospital service based on a team approach. Patients with multiple organ failure can often recover, if they are admitted to LTCH care on a timely basis, sooner rather than later. CMS should strive for best clinical practices. CMS LTCH payment policies do not encourage best clinical practices. That is, CMS needs to replace questionable payment policy judgment with sound clinical judgment.

2. Changes to Short-Stay Outlier Policy

CMS has claimed that stays in LTCHs that last less than 5/6 of the geometric mean LOS for all visits to LTCHs for the particular DRG are indicative of cases that "could have been treated more appropriately in an acute hospital subject to the acute care hospital inpatient prospective payment system."[22] Thus, the SSO policy was meant to discourage LTCHs from admitting such cases.

Since originally implementing the SSO policy at the inception of the LTC-PPS in 2003, CMS has analyzed MedPAR data and determined that LTCHs were still admitting cases that could be more appropriately treated in acute care hospitals. As a result CMS made adjustments to the

[22] 67 FR 55995 as quoted on 72 fr 4804e

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SSO policy in RY 2007 that essentially created further reductions to payments to LTCHs for these cases.

CMS has decided to take a more proactive approach this year and has again proposed changes to further reduce payments for SSO cases, even though data are not yet available to determine how effective the RY 2007 SSO policy changes have been. ***Exhibit II.C.2-1*** displays the impact of the SSO outlier policy in aggregate and by each of the SSO options for RY 2007 compared to RY 2008.

As we can see from ***Exhibit II.C.2-1***, the proposed SSO policy does not impact the number of SSO cases identified, but does decrease payments for SSO cases by approximately 6.2 percent. Approximately 31.0 percent of the SSO cases were simulated to be paid using the new SSO option under the proposed rule. For these VSSO cases payments decrease by nearly 24 percent under the proposed short stay approach.

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Exhibit II.C.2-1. Average RY2008 Payment with proposed Standard Federal rate, Area Wage Adjustment, SSO Approach for very short stay outlier cases, and Expansion of "25% Policy" by Short Stay Payment Type

Type of LTCH Discharge	Number of LTCH Cases RY2008	Percent of Cases RY2008	Percent of Covered Days	RY2007 Payment RY2007 WI[1]	RY2008 Payment RY2007 WI[2]	RY2008 Payment RY2008 WI[3]	RY2008 Payment RY2008 WI w / New SSO[4]	RY2008 Payment w / All Proposed Changes	RY2008 Average Covered LOS
All LTCH Discharges	130,599	100.00%	100.00%	$ 31,849.79	$ 32,090.37	$ 31,956.14	$ 31,621.60	$ 30,570.16	26.6
Regular LTC-PPS	69,590	53.29%	60.48%	$ 36,097.45	$ 36,234.54	$ 36,018.77	$ 36,018.77	$ 34,512.95	30.2
Short Stay Outliers (SSO)	47,107	36.07%	17.35%	$ 14,514.08	$ 14,916.98	$ 14,882.45	$ 13,954.15	$ 13,389.00	12.8
High Cost Outliers (HCO)	13,902	10.64%	22.17%	$ 66,210.04	$ 69,537.79	$ 69,473.92	$ 69,473.92	$ 69,051.95	55.4
Short Stay Outlier Payments									
All Short Stay	47,107	100.00%		$ 14,514.08					12.8
	47,107	100.00%			$ 14,916.98				12.8
	47,107	100.00%				$ 14,882.45			12.8
	47,107	100.00%					$ 13,954.15		12.8
	47,107	100.00%						$ 13,389.00	12.8
Cost	32,568	69.14%		$ 15,020.83					14.1
	31,217	66.27%			$ 15,551.38				14.2
	31,217	66.27%				$ 15,552.27			14.2
	24,803	52.65%					$ 15,538.49		15.1
	24,803	52.65%						$ 14,851.01	15.1
Per Diem	471	1.00%		$ 5,031.31					3.2
	478	1.01%			$ 4,897.32				3.1
	478	1.01%				$ 4,874.09			3.1
	33	0.07%					$ 4,667.64		3.1
	33	0.07%						$ 4,637.52	3.1
Full LTCH DRG	-	-		$ -					-
	-	-			$ -				-
	-	-				$ -			-
	-	-					-		-
	-	-						-	-
Blended Rate	14,068	29.86%		$ 13,658.41					10.3
	15,412	32.72%			$ 13,982.11				10.4
	15,412	32.72%				$ 13,877.22			10.4
	7,666	16.27%					$ 17,127.56		13.8
	7,666	16.27%						$ 16,269.00	13.8
Comp Full IPPS	14,605	31.00%					$ 9,618.81		8.4
	14,605	31.00%						$ 9,414.17	8.4
Expanded 25% Rule	8,172	6.26%						$ 10,315.70	N/A

[1]RY2007 calculated under current law in effect for LTCH discharges after 10/1/2006 for LTC-PPS and IPPS area wage index and DRG weights

[2]RY2008 calculated with proposed standard amount and high-cost outlier updates, market basket inflation update and current law for RY2007 in effect for LTCH discharges after 10/1/2006 for LTC-PPS and IPPS area wage index and DRG weights.

[3]RY2008 calculated with proposed standard amount and high-cost outlier updates, market basket inflation update, area wage adjustment update and current law for RY2007 in effect for LTCH discharges after 10/1/2006 for LTC-PPS and IPPS area wage index and DRG weights.

[4]RY2008 calculated with proposed standard amount and high-cost outlier updates, market basket inflation update, area wage adjustment update, and the SSO approach withIPPS area wage index and DRG weights.

Source: Lewin Group analysis of Proposed RY 2008 LTC-PPS payment update

3. *SSO policy does not identify outliers*

Given the fact that the SSO policy continues to cover the same cases we continue to disagree with the CMS conclusion that the SSO policy does not harm the financial integrity of LTCHs. This is because CMS defines an SSO case in such a way that it is essentially impossible for LTCHs to admit a smaller percentage of SSOs in any given year. In fact, as we shall see when

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we discuss the margins associated with SSO cases, the proposed very short stay policy only poses to increase the harm to the financial integrity of LTCHs.

CMS uses a relative measure of "short stay" that guarantees that approximately 30 to 40 percent of cases will always be considered "short," regardless if these stays are appropriate for LTCH treatment. A short stay is defined as a "stay shorter than 5/6 of the geometric mean length of stay." Length of stay generally follows a log-normal distribution, for which the geometric mean is equal to the median length of stay (half of stays are longer, and half shorter).

Statistically, stays less than 5/6 of the geometric mean will *always* account for about 30 to 40 percent of cases, regardless of the expected-stay threshold the LTCHs require for an admission. By defining a short stay in this manner, it is essentially guaranteed that short stays will account for about 30 to 40 percent of cases. To object that this is "too many" is akin to objecting to the fact that LTCHs have 50 percent of cases that are below the median.

Appendix 2 shows the 50 DRGs in the 2005 LTCH MedPAR data with the highest number of short stay cases. This indicates that, by and large, LTCH DRGs show a consistently high percentage of SSO cases -- in the 30 to 45 percent range, which further indicates that the large portion of SSO cases is due to the CMS definition of SSOs and not LTCH patient selection. That is, even for DRG 565 and 566, dealing with patients needing ventilator support, which are the patients most often cited as the patients associated with appropriate LTCH care, a large number of SSO cases are selected. This does not seem to support the notion that the SSO policy impacts cases that should not be treated in LTCHs. Instead, it lends evidence that it arbitrarily selects cases regardless of the appropriateness of the treatment setting.

The standard thresholds for identifying cases that are statistical outliers (i.e. significantly different from typical cases) are usually greater than 95 to 99 percent. That is, a case would have to be different or more extreme than 95 to 99 percent of the other cases. In this case, CMS expects to identify cases that are less costly than the normal case. Thus, the LTC SSO policy, on average and as intended, pays a significantly lower per diem reimbursement rate than LTCHs receive for a typical case ($1,090 versus $1,192). However, the current SSO policy does not seem directed at cases that are less costly than the typical case. According to the MedPAR data, costs per day were higher for SSO cases, $1,352, in comparison to non-outlier cases (i.e. non-SSO and non-HCO cases), $1,140, implying that the resources used for these cases are more intensive. This is evidence that LTCHs are being underpaid under the SSO policy and that the SSO policy is not pinpointing cases that CMS intended.

To demonstrate that the frequency of SSOs is about the same regardless of the admission policies of LTCHs, we considered what would happen if LTCHs eliminated all cases that are currently considered SSOs, and calculated the percentage of cases that would then be considered SSOs. That is, we excluded all current SSO cases from the LTCH case distribution and recomputed the geometric mean LOS using only remaining non-SSO cases. We then set a new SSO threshold at 5/6 of the new geometric mean LOS. As shown in ***Exhibit II.C.3-1***, this results in about 34 percent of the cases being identified as SSOs. This compares to about 36 percent for the original distribution. As noted above, the fact that LTCHs produce close to 40 percent is expected given the LTC-PPS definition of SSOs. It is simply unavoidable.

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Exhibit II.C.3-1: Re-estimating the Percent of SSOs after Removing the Original SSOs from the Distribution of LTCH Cases

All LTCH Discharges in 2005	
Number of Discharges	130,599
Number of SSO Cases	47,107
Percent of SSO Cases	36%
LTCH Cases Excluding all current SSO Cases	
New Number of Discharges	83,492
New Number of SSO Cases	28,767
New Percent of SSO Cases	34%

One of the criteria for a hospital to be certified as an LTCH is a 25-day average length of stay. Note, that this is an average, so there is an expectation that some cases would fall below the mean and some above the mean. With this in mind, we thought it would be important to better understand the distribution of LTC-PPS SSO cases. ***Exhibit II.C.3-2*** shows this distribution by LOS categories (e.g., 1-4, 5-9, etc.), as well as the number and percent of deaths by the SSO LOS categories.

Exhibit II.C.3-2: Distribution of SSO Cases by LOS and Death Status

	Number of SSO Cases	SSO Percentage of Total Cases	Cumulative SSO Percentage of Total Cases	Number of SSO Deaths	Percentage of SSO Cases Ending in Death
Days: 30+	631	1.3%	1.3%	154	24.4%
Days: 25 - 29	2,321	4.9%	6.3%	558	24.0%
Days: 20 - 24	3,990	8.5%	14.7%	798	20.0%
Days: 15 - 19	11,208	23.8%	38.5%	1,972	17.6%
Days: 10 - 14	12,907	27.4%	65.9%	2,546	19.7%
Days: 5 - 9	10,580	22.5%	88.4%	2,971	28.1%
Days: 1 - 4	5,470	11.6%	100.0%	2,153	39.4%
Total	47,107			11,152	23.7%

Source: Lewin Group analysis of the 2005 Medicare Provider Analysis and Review (MedPAR) data.

The exhibit shows a clustering of SSO cases in the 5-9, 10-14 and 15-19 day LOS categories. The 1-4 LOS category represents only 11.6 percent of SSO cases, of which 39.4 percent are deaths. It seems confounding that over 6 percent of SSO cases have a length of stay greater than 25 days, which is the average requirement for LTCH certification according to CMS. Just as inexplicable is the fact that cases slightly below the 25-day requirement are considered short-stay outliers. As shown in ***Exhibit II.C.3-2***, 8.5 percent have a length of stay between 20 and 24 days. These cases do end up with a reduced payment. In fact payments are reduced by over 40 percent for SSO visits in the 30+, 25-29 and 20-24 LOS categories. That is, the SSO payment for these cases is on average over 40 percent lower for these cases in comparison to their reimbursement

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assuming no SSO policy. These findings reveal inconstancies in CMS LTCH policies as well as the inappropriateness of the current methodology of identifying "outliers."

4. SSO cases should not be paid on an IPPS basis

Exhibit II.C.4-1 presents a comparison of the percentage of SSO cases (defined as "cases with an average LOS less than 5/6 of the geometric mean LOS") to the percentage of acute care hospital (ACH) cases that would be defined as short stay cases using the LTC-PPS definition.

Exhibit II.C.4-1: Short-stay Discharges for IPPS and LTC-PPS Compared

Hospital Type		Discharges	Number of Short Stay Discharges	Percentage of Short Stay Discharges	Number of Short Stay Deaths	Percent of Short Stay Deaths
IPPS (2005)		12,895,893	5,064,116	39.27%	218,406	4.31%
LPPS (2005)	SSO Discharges	130,599	47,107	36.07%	11,152	23.67%
	VSSO Discharges	130,559	14,605	11.19%	5,517	37.77%

Both types of hospitals show similar proportions of short stay cases. About 39.3 percent of IPPS discharges were short stays in 2005, while LTCHs had about 36.1 percent of such cases that year. While the percentage of short stay cases is similar across settings, the composition is different. In 2005, about 23.7 percent of the LTC-PPS short stay cases ended with the death of the patient, while less than five percent of IPPS short stays ended with deaths. These figures are similar to what we found last year when we looked at the 2003 and 2004 MedPAR, so there seems to be a very stable and concrete difference in cases.[23] These facts suggest that short-stay patients in LTCHs are more severely ill than their counterparts in ACHs. After observing LTCH operations for many years, we believe that deaths are difficult to predict for LTCH patients, most of whom are medically unstable due to multiple organ failures upon admission.

Appendix 3 compares the average number of Medicare covered days and Medicare case costs between LTC-SSO cases and IPPS hospitals overall and by DRG. We weighted the data by the LTC distribution of cases across DRGs in order to make comparisons of the overall averages. The number of covered days is on average over 70 percent higher for LTC-SSO cases in comparison to covered days in IPPS facilities. Costs are approximately 46 percent higher for LTC-SSO cases. ***Appendix 4*** provides comparisons for the average number of covered days and case costs between LTC-VSSO cases and IPPS cases. As expected, the gap tightens somewhat since VSSO cases can not have more covered days than the 5/6 of the geometric mean threshold and they are based upon the IPPS distribution, but there still is a significant difference with IPPS cases. Even though the average number of covered days is about 18 percent less, costs are about 13 percent more for LTC-VSSO cases. Again, this provides further evidence that the cases identified by the SSO policy are not cases typically treated in IPPS facilities. Therefore, it is incorrect to base payment for these cases treated in LTCHs on IPPS payment policies.

[23] Lewin's Final Report: Analysis of Long-term Care Hospital RY 2007 PPS NPRM, March 9, 2006

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5. Margins for LTC-PPS SSO Cases

As we noted above, in aggregate, the short stay rules apply to slightly more than one-third of all discharges, and the above-mentioned rules generally reduce the payment to below the LTC-DRG PPS rate, thus undermining the assumption that having a standard DRG rate allows losses on long stays to be offset by gains on short stays. Put another way, the short stay rules (particularly the new SSO policy) undermine the basic principal of averaging utilized by CMS when originally establishing 2003 LTC-PPS rates and more generally all other CMS prospective payment systems.

Exhibit II.C.5-1 shows that the margin for LTC-PPS SSO cases is -8.1 percent in RY 2008, nearly two times[24] lower than overall margins. The LTC-PPS SSO margin for RY 2007 is similar at -7.90 percent. We calculate the margins in ***Exhibit II.C.5-1*** using our revenue model and charge data from the MedPAR file. Charges are converted to costs using the cost-to-charge ratio and inflated to 2007 and 2008 using the market basket index updates similar to the HCO cost calculations. We then standardize these estimates to the overall margin estimates calculated using the Medicare cost report data to account for the fact that overall case-level margins are approximately 20 percentage points lower than margins calculated from the MCR. We believe that these estimates present an accurate description of the relative differences in margins across case types. The margin for VSSO cases is significantly lower at -17.8 percent in RY 2008.

Exhibit II.C.5-1: Margins for LTCH PPS SSO cases and Cases Subject to the 25% Policy: 2007 and 2008

Discharge Destination	Margin
RY 2007	**%**
All LTCH Discharges	2.87
LTCH Discharges that Died	-6.43
All LTCH Short Stay Outliers	-5.06
Short Stay Outliers that Died	-8.54
RY 2008	
All LTCH Discharges	-4.31
LTCH Discharges that Died	-8.97
All LTCH Short Stay Outliers	-8.05
Short Stay Outliers that Died	-11.38
Very Short Stay Outlier Discharges	-17.75
All LTCH 25 Percent Rule Discharges	-39.61

Source: Lewin Group analysis of CY 2005 MedPAR data

Also noteworthy is the margin for LTCH cases that end in death. The margin for deaths is -8.97 overall in RY 2008. The SSO death cases have an even lower margin of -11.4 percent. As mentioned throughout this report, end-of-life care is indicative of more intensive and more costly treatment. Also, it is difficult to predict these cases prior to admission to a LTCH. In

[24] -8.05 ÷ -4.31 = 1.8

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other words, these cases may not be the cases that CMS aims to have treated in acute care facilities.

D. The 25 percent policy analysis

This section provides analysis of the current-law 25 percent policy as well as the proposed expansion of the 25 percent policy to free standing hospitals. We start with a brief assessment of the clinical implications from the 25 percent policy and then move to feasibility, resource and financial considerations.

The clinical arrangements here are much like those presented for the SSO rule. LTCHs are specialized providers that treat complex patients in a team oriented fashion to produce multi-dimensional results; as opposed to the primarily single diagnosis approach of ACHs.

The additional arrangement here is the CMS assumption that in certain instances ACHs can take back up to 75 percent of LTCH cases. There are two problems with this assumption. First, why the 25 percent limit? This is arbitrary and has no obvious clinical content. Second, if ACH hospitals and LTCHs have worked out transfer arrangements that are in the patient's best interest in terms of recovery, how is it that an arbitrary payment rule can improve upon this situation? It is unlikely that ACHs in the near term, if ever, will develop the resources and clinical management skills required to replace LTCH services. Given the differences in mission and treatment philosophy between ACHs and LTCHs it is not clear if trying to meld LTCH services into ACHs is feasible or desirable.

When CMS first implemented the 25 percent policy for co-located hospitals, the objective was to ensure that "long-stay patients who could reasonably continue treatment in an acute care hospital would not be unnecessarily discharged to an onsite LTCH, a behavior that would undermine the Medicare IPPS DRG payment system for acute hospitals."[25] As discussed above, LTCHs and ACHs provide different levels of care and it is not clear that an ACH can provide the same level of care that a LTCH can.

When an ACH patient is referred to a LTCH for admission, the LTCH performs certain preliminary inquiries to determine whether or not the patient should be treated in the facility. According to data from several NALTH members, more than half of their referrals do not get admitted to the LTCH. The vast majority of these cases are denied due to the LTCH deciding that the patient is better suited for other levels of care. Some of these hospitals have noted that they use the NALTH criteria to determine the appropriateness of LTCH care. Other reasons the patient may not end up as an admission in the LTCH is that the referral was cancelled from the referral source, the patient choose another LTCH, or the patient's insurance denied coverage for the admission.

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[25] FR 72, p 4809

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Several LTCH chief executive officers have confirmed that it is impossible for them to know which patients were HCOs in the acute care hospital prior to being transferred to the LTCH. Because it is difficult to identify these ACH HCOs at the time of LTCH admission, LTCHs may believe they are reaching the 25 percent rule prematurely. This is problematic as it could lead to an increased number of patients being denied care unnecessarily.

Perhaps patient and facility level criteria at both ends (the ACH before discharge and the LTCH before admission) should be developed and standardized to insure that LTCHs and ACHs are conforming to the payment principles developed by CMS as well as appropriate medical practices.

It is difficult for LTCHs to predict when the 25 percent threshold will be met. There are no alternative criteria for LTCHs to use that conform to the principles upon which the payments are based, so it will be difficult for the 25 percent policy to actually meet the intended objective. In fact, from a purely economic perspective, the 25 percent policy seems to promote the strategy of LTCHs simply refusing patients who they would expect to produce the lowest margins regardless of whether the patient is an appropriate candidate for LTCH treatment. This will result in patients unnecessarily being denied appropriate care and the care that the Medicare enrollee is entitled to and actually prefers.

1. Methodology for 25 Percent Policy Analysis.

As mentioned earlier, we used a specially requested patient identifiable 2005 MedPAR dataset. This dataset allowed us to track a Medicare beneficiary through all of his or her Medicare inpatient hospital stays resulting in discharges during CY 2005. Therefore, we were able to identify discharges from other hospitals (including ACHs, inpatient rehabilitation facilities, and psychiatric hospitals) that occurred on the same day as admissions to LTCHs. [26] These same day discharge/admission transactions were identified as transfers from a non-LTCH hospital to a LTCH hospital, which would be eligible to be counted towards the applicable 25 percent threshold.[27]

After the eligible cases were identified and sorted based on admission date, we then counted the cases subject to the applicable 25 percent threshold based on the admission date. These counts were on a discharging hospital, admitting LTCH basis. Thus, it is possible that a single LTCH could reach the applicable threshold with multiple hospitals. In order to determine if the applicable threshold is reached, we use the formula below:

$$\text{Cases}_{hlc}/\text{Cases}_{l} > \text{Threshold}_{l} \qquad \text{where:}$$

[26] Note that the vast majority of admissions to LTCHs (over 80 percent) are ACH referrals.

[27] Note that there are some exceptions to the 25 percent threshold. For instance, patients transferred to LTCHs after being high-cost outliers in an acute hospital are not counted toward the threshold. Also, higher thresholds exist for rural LTCHs and LTCHs that are urban single or located in metropolitan statistical areas with dominant hospitals.

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$Cases_{hlc}$ = the cumulative count of eligible cases through case *c* from discharging hospital, *h,* and LTCH, *l*
$Cases_{l}$ = the total number of admissions for LTCH, *l*, and
$Threshold_{l}$ = the applicable threshold for the LTCH,*l*.

Thus, once the first case for any discharging hospital/admitting LTCH combination is associated with a proportion greater than the applicable threshold, all succeeding eligible cases (based on admission dates) for that combination will also fall under the 25 percent policy. Implicit in the 25 percent policy criteria is the fact that after a certain arbitrary date,[28] all cases from that discharging ACH will receive a reduced payment, regardless of the severity, cost or appropriateness of the transfer of the case to the LTCH.

We calculate a 25 percent policy payment which is the lesser of an IPPS equivalent payment and the payment it would have received under the LTC-PPS (including the SSO payment if applicable). For this reason, it is possible that not all 25 percent policy eligible cases receive the 25 percent policy payment. ***Exhibit II.D.1-1*** displays the number of cases eligible for 25 percent policy payments. Out of the 8,668 eligible, most cases, 8,172 actually resulted in reduced payments. The other 496 were all SSO cases and were paid at the "lesser of" SSO payment options. The average payment for the 8,172 cases decreases from $27,114 before the application of the 25 percent policy to $10,316 after its application.

Exhibit II.D.1-1: Eligible for 25 Percent Policy Cases for Effective 25 Percent Policy Cases

Type of 25% Rule Case	Cases	% Cases
Total 25 % Rule Cases	8,668	
Cases Not Impacting Payments	496	5.7
SSO Cases	496	100.0
Cases Impacting Payments	8,172	94.3
SSO Cases	3,138	38.4
LTC-DRG Cases	4,441	54.3
HCO Cases	593	7.3

Considering that the average payment for 25 percent policy decreases by nearly 62 percent, the estimated margins for 25 percent policy cases are -39.6 percent (see ***Exhibit II.C.5-1***). This is further evidence that LTCH cases are not the same as IPPS stays. Therefore, paying LTCHs as if they were IPPS hospitals can lead to extremely disruptive financial situations for LTCHs with a high number of cases affected by the 25 percent policy.

[28] i.e., the date of the last case admitted that is less than 25 percent of the cases from the discharging ACH.

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There are 368 total LTCHs in our 25 percent policy payment simulation database.[29] Of those 188 were identified as HwHs and 180 were free-standing LTCHs. There were 112 HwHs and 67 free-standing LTCHs subject to the 25 percent policy.

Exhibit II.D.1-2a displays the number of cases in HwHs that we identified as transfers (i.e., same-day admissions) eligible for the 25 percent policy and for which we calculated a 25 percent policy payment. Out of the 58,181 cases in HwHs, 42,960 were transfer cases with 7,052 being HCO cases in the discharging ACH. Note that ACH HCO cases are not included in the count of transfers potentially affected by the 25 percent policy. Of the 42,960 same day admissions, there were 5,109 cases subject to the 25 percent policy (i.e., would be paid according to the 25 percent policy payment methodology). ***Exhibit II.D.1 -2b*** presents similar statistics for free-standing hospitals resulting in 3,559 cases subject to the 25 percent policy.

Exhibit II.D.1-2a: Count of 25 Percent Policy Discharges: HwH LTCHs

LTCH Classification	Number of Providers	Number of LTCH Cases	Same-day Admissions	Allowed Same-day Admissions	Same-day Admissions Subject to Rule	Same-day Amissions Where Previous Discharge was Outlier [2]
All Providers	**188**	**58,181**	**42,960**	**37,851**	**5,109**	**7,052**
By Location						
Large Urban	73	25,560	18,608	16,319	2,289	3,177
Other Urban	102	29,531	22,082	19,415	2,667	3,687
Rural	13	3,090	2,270	2,117	153	188
By Ownership/Control						
Voluntary	54	14,347	10,921	9,028	1,893	1,643
Proprietary	130	42,517	31,033	27,916	3,117	5,238
Government	4	1,317	1,006	907	99	171
By Region						
Midwest	48	12,782	9,423	8,310	1,113	1,965
Northeast	15	3,361	2,582	2,136	446	444
South	116	39,492	29,274	25,839	3,435	4,135
West	9	2,546	1,681	1,566	115	508
By Bed Size						
1: 1-24	24	4,464	3,241	2,798	443	515
2: 25-49	132	34,956	25,875	22,155	3,720	4,690
3: 50-74	19	7,645	5,583	5,251	332	992
4: 75-124	9	6,828	5,138	4,738	400	455
5: 125-199	3	2,635	1,972	1,758	214	265
6: 200 - 299	0	0	0	0	0	0
7: 300+	1	1,653	1,151	1,151	0	135

1 Based on file from CMS
2 If transferring hospital received an outlier payment, case was assumed to be an outlier case and not subject to 25% rule
Source: Lewin Group analysis of December 2006 MedPAR release

[29] This differs from the 369 providers in other analyses in this report. The discrepancy is due to missing values for certain data fields.

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Exhibit II.D.1-2b. Count of 25 Percent Policy Discharges: Free-Standing LTCHs

LTCH Classification	Number of Providers	Number of LTCH Cases	Same-day Admissions	Allowed Same-day Admissions	Same-day Admissions Subject to Rule	Same-day Amissions Where Previous Discharge was Outlier [2]
All Providers	180	72,418	52,040	48,481	3,559	7,210
By Location						
Large Urban	108	52,466	37,893	35,801	2,092	5,360
Other Urban	61	17,776	12,624	11,343	1,281	1,716
Rural	11	2,176	1,523	1,337	186	134
By Ownership/Control						
Voluntary	68	24,459	17,674	15,942	1,732	2,511
Proprietary	101	43,870	31,589	29,842	1,747	4,407
Government	11	4,089	2,777	2,697	80	292
By Region						
Midwest	36	11,291	7,664	7,306	358	1,601
Northeast	26	14,449	10,962	10,032	930	978
South	89	34,331	24,416	22,385	2,031	3,013
West	29	12,347	8,998	8,758	240	1,618
By Bed Size						
1: 1-24	17	3,219	2,229	1,986	243	280
2: 25-49	64	16,935	12,286	10,707	1,579	1,799
3: 50-74	38	15,487	10,934	10,556	378	1,849
4: 75-124	33	16,972	12,349	11,824	525	1,714
5: 125-199	15	9,744	6,728	6,315	413	752
6: 200 - 299	10	7,799	5,904	5,521	383	654
7: 300+	3	2,262	1,610	1,572	38	162

1 Based on file from CMS
2 If transferring hospital received an outlier payment, case was assumed to be an outlier case and not subject to 25% rule
Source: Lewin Group analysis of December 2006 MedPAR release

2. *Expected Difference between 25 Percent Policy Visits and non-25 Percent Policy Visits*

There is no way to predict ahead of time which cases will be 25 percent policy cases. According to CMS, these will be cases that should have continued to have been treated in an IPPS facility. However, as discussed above, it is not clear as to whether the 25 percent policy will pinpoint those cases. Considering the issues identified by the SSO analysis, it is more likely that the 25 percent policy will impact cases that look like other LTCH cases.

When assuming that the distribution of cases in RY 2008 will be the same as those on the 2005 MedPAR file we found that the distribution of cases affected by the 25 percent policy are similar to the distribution of cases before the introduction of the rule. That is, out of the 8,172 cases that resulted in a payment change because of the 25 percent policy, 54.3 percent were previously LTC-DRG based payments, 38.4 percent were SSO based, and 7.6 were HCO based. The corresponding estimates for all cases before the 25 percent policy were 53.3, 36.1 and 10.6 percent respectively.

Appendix 5 shows the comparison of the number of covered days and case costs between cases we identified as being affected by the 25 percent policy and IPPS cases for the same DRG. We see that the average number of Medicare covered days for LTC-25 percent policy cases is nearly 250 percent higher than DRG comparable cases in IPPS hospitals. Case costs are approximately 175 percent higher. Given the stark disparity in case costs and the number of covered days, it is evident that these LTCH 25 percent policy cases are not similar to IPPS cases, which

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undermines the main justification given by CMS for the rule. In other words, the 25 percent policy may not be identifying cases that should be treated in IPPS facilities. These findings are also an indication that there is an extremely high risk for financially catastrophic effects for any LTCHs unable to change their admission practices to avoid treating cases that will be impacted by the 25 percent policy.

We have data on same-day admission cases to LTCHs versus non-transfer cases to LTCHs. This comparison may be relevant since same-day admissions are the only cases that could be eligible for 25 percent policy payments. It is not clear that there is any difference between these two types of cases that justifies having such a dramatic adjustment to reimbursement for 25 percent policy cases. Non-transfer cases had a LOS of 31.4 days versus 25.7 days for same day admissions; however, the intensity and severity of care seemed to be higher on the same-day admission cases, even though costs per day were similar at approximately $1,275 across case-types. The mortality rate (14.2 percent versus 9.6 percent) and HCO rate from previous hospital (13.1 percent versus 1.2 percent) were significantly higher for same-day admission cases.

3. Market Area Impacts after the 25 Percent Policy

We also evaluated the market areas for LTCHs affected by the 25 percent policy versus LTCHs not subject to the 25 percent policy. LTCHs subjected to the 25 percent policy, on average share their CBSA with 23 ACHs and 5 LTCHs. Whereas LTCHs, not subjected to the rule share the CBSA with 17 ACHs and 4 LTCHs. It is expected that LTCHs not subject to the rule would have more hospitals in their market area as this helps spread out the case load and makes it easier to avoid reaching the 25 percent threshold.

As noted above, LTCHs are expected to experience large financial losses on cases impacted by the 25 percent rule. We have no way to determine when a LTCH would decide to close, but it seems unlikely that LTCHs will be able to operate on an ongoing basis having a significant portion of their cases producing close to -40 percent margins. For instance, if 10 percent of cases are paid at -40 percent margins, that would negatively impact total margins by -4 percent. If 20 percent of cases are paid at -40 percent margins, that would negatively impact total margins by -8 percent.

In order to illustrate potential impacts on the access to LTCH services within market areas, we modeled various assumptions about when an LTCH may consider closing. ***Exhibit II.D.3-1*** displays a series of 4 illustrative scenarios showing the distribution of CBSAs[30] by the number of LTCHs located within their borders: (1) There is no 25 percent rule (2) LTCHs would withdraw from the market (i.e. shut down) if 30 percent or more of their cases receive the reduced payment of the 25 percent rule (3) LTCHs would withdraw from the market if 20 percent or more of their cases receive the reduced payment of the 25 percent rule; and (4)

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[30] Out of the 440 CBSAs, which are the market designations currently used by CMS to group LTCHs for their wage index calculations, 169 contained at least one LTCH.

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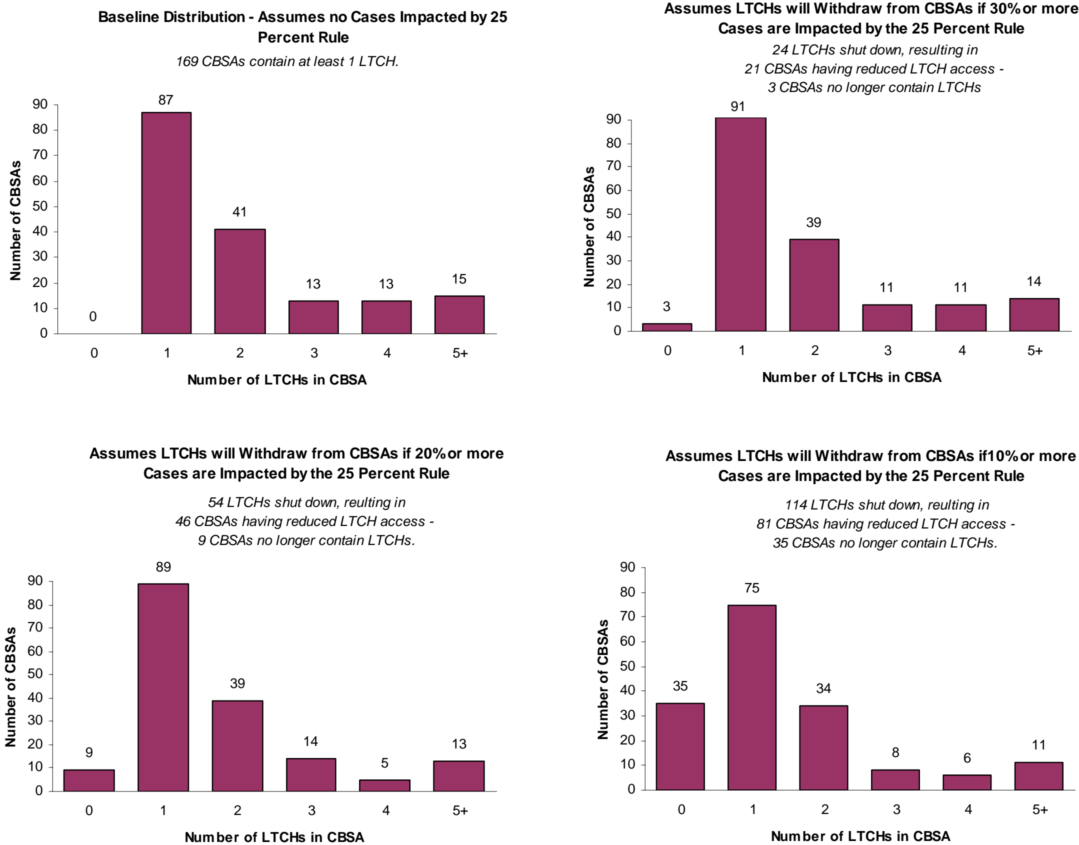
LTCHs would withdraw from the market if 10 percent ore more of their cases receive the reduced payment of the 25 percent rule.

Exhibit II.D.3-1: Illustrative Impact of the 25 Percent Policy on Access to LTCH Services



Source: Lewin Group analysis of Proposed RY 2008 LTC-PPS payment update

The first scenario (top-left graph) displays the baseline scenario, which essentially provides a depiction of the count of LTCHs before the implementation of the 25 percent rule. In this case, of the 169 CBSAs currently containing an LTCH, 87 contain one LTCH and 15 contain 5 or more LTCHs. There are a total of 368 LTCHs spread across the 169 CBSAs.

The second scenario (top-right graph) displays the number of LTCHs in each of the 169 CBSAs assuming that LTCHs would withdraw from the market if 30 percent or more of their cases receive the reduced payment of the 25 percent rule. That is, at least 55 percent of their cases would need to be eligible for the 25 percent rule, since the payment for the first 25 percent are not impacted by the rule. In this case, a total of 24 LTCHs would shut down affecting the

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availability of LTCHs in 21 CBSAs. There would now be 3 CBSAs that no longer have LTCHs located in them.

Lowering the percentage of cases needed to cause a LTCH to consider withdrawing from the market to 20 percent increases the number of LTCHs that shut down (i.e. more hospitals have at least 20 percent of their cases impacted by the rule compared to 30 percent as illustrated in scenario 2 above). A total of 54 LTCHs would shut down changing the availability of LTCHs in 46 CBSAs. Under this third scenario (bottom-left graph) there would be 9 CBSAs with no LTCHs in them. Notice that the distribution is shifting further to the left as more LTCHs shut down and the number of LTCHs per CBSA decreases.

The fourth scenario (bottom-right graph) displays the number of LTCHs in each of the 169 CBSAs assuming that LTCHs would shut down if 10 percent or more of their cases receive the reduced payment of the 25 percent rule. More LTCHs are assumed to shut down as we lower the threshold even further. In this illustration, 114 LTCHs would shut down and nearly half (81) of the 169 CBSAs would be impacted. This could lead to a dramatic reduction in access to LTCH services, particularly as 35 CBSAs would no longer have any LTCHs.

In the framework of this analysis, as well as the notion previously discussed that the 25 percent rule tends to have a greater impact on hospitals in areas with fewer LTCHs, it becomes evident that the 25 percent rule may have a self-fulfilling prophecy. That is, as LTCHs increasingly withdraw from market areas, an increasing number of LTCHs will be impacted by the rule and could ultimately close as well.

Note that this CBSA-level analysis is performed under the assumption that the distribution of cases and LTCHs in RY 2008 will be the same as those on the 2005 MedPAR file. We did not adjust for any possible changes in the admitting patterns of LTCHs. Although, it is expected, for reasons previously described, that many LTCHs will not be able to avoid being impacted by the 25 percent rule.

E. The Proposed SSO Policy and 25 Percent Policy Disregard the Fundamental Averaging Logic Underlying Prospective Payment Systems

Our report to NALTH on the proposed RY 2007 LTCH-PPS update rule notes that from the very beginning, the CMS prospective payment systems have been based on systems of averaging.[31] This is fundamental to how prospective payment systems work: standard payments allow losses from high-cost cases to be offset by gains on low-cost cases. This allows for resource use to be covered “on average” across all of a provider’s cases for providers of average efficiency.

In the original report to Congress for the acute care hospital PPS, the Health Care Financing Administration (HCFA), now CMS, noted that “in a prospective payment system, hospitals are

[31] Lewin’s Final Report: Analysis of Long-term Care Hospital RY 2007 PPS NPRM, March 9, 2006

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protected from undue financial risk by the process of averaging -- the law of large numbers"[32]; that is, even though there is a wide variation in costs among all cases, the average cost for any particular subset of cases will show much less variation. This 1982 report to Congress notes that averaging can take place within a DRG and across DRGs for any given hospital and further, that averaging, in and of itself, is not adequate to fully protect hospitals from losses due to cost variation. The use of "features that augment this protection," such as high-cost outlier payments and payment pass-throughs for direct and indirect medical education, are also required to maintain solvency. The LTC-PPS outliers deviate markedly from this sense of fair play.

Indeed, the RY 2008 NPRM moves LTC-PPS further away from the concept of averaging. As we noted last year, because a short stay is defined as a stay shorter than 5/6 of the geometric mean length of stay, short stays account for about the same percentage of cases (40 percent) for both ACH and LTCH stays. By defining a short stay in this manner, it is essentially guaranteed that short stays will account for 40 percent of cases. To systematically exclude these cases from the prospective payment averaging system is to abandon the principle of averaging. It is widely recognized that including these types of cases is necessary to produce appropriate averaging for the IPPS; it is equally necessary for the LTC-PPS.

The current LTC-PPS is highly complex and is made even more so by the 2008 NPRM. As we note above, the premise underlying the proposed rules' very short stay IPPS payments are faulty. From a payment perspective the concept that these new short-stays are very much like IPPS cases is demonstrably false. As we note in ***Exhibit II.C.5-1*** payment margins for these cases is on the order of –17.8 percent. ***Appendix 4*** indicates why this is the case – overall and for most DRGs the LTCH VSSO cases are more resource intensive. To set up a major portion of a PPS with average losses in this range is punitive and strays from a sense of fair play. Under the basic logic of prospective payment systems, you "win" on some cases and "lose" on other cases, but on average, your hospital will be viable**.**

CMS originally argued that LTC-PPS short-stay cases should be paid such that their costs are just covered. This is a retreat from the original IPPS concept of averaging protection through the law of large numbers, but the LTCH industry has adjusted to this. The use of IPPS payment rates to pay for LTC-PPS SSOs is a retreat from the basic notion that PPSs are based on averages such that hospitals win some cases, lose on some others, and, on average, are not placed at undue financial risk. As we note elsewhere (and show in ***Appendix 3****)*, LTCH SSO cases require more intensive resource use, by about 46 percent, than the cases that underlie the IPPS payment weights. Indeed, the LTCH SSO cases have an approximately 73 percent longer length of stay than comparable DRGs under IPPS. The PPS was designed to provide incentives for hospitals to reduce lengths of stay and increase efficiencies but also to cover costs of hospitals with average efficiencies.

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

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Under the currently proposed rule, averaging is not only taken away – it is reversed. The very cases required to balance the system as averages would be widely underpaid, and account for over one-third of all LTC-PPS cases. To have over one-third of cases paid at a –8.1 percent margin, and the other 64 percent paid to barely cover or paid slightly less than costs, is an untenable situation, should CMS intend to ensure the stability of care delivery in the LTCH setting.

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

From a clinical perspective the new short-stay outlier policy component seems off the mark as well. Extensive conversations with LTCH physicians and physicians that refer to LTCHs indicate that it is entirely appropriate to move patients out of the acute care hospital setting to the LTCH setting as soon as the patients are stabilized. The acute care hospital is not designed to provide the team support required to condition patients with complex medical conditions.

There is also the issue of deaths. As we noted, SSO cases have a mortality rate of 23.7 percent and very short stay cases have a mortality rate of 37.8 percent. Because these cases are difficult to predict, we recommend that these cases not be paid under the new policy.

Concerning the 25 percent policy, our analysis indicates that this is not a rational payment policy from an equity perspective. To pay IPPS rates for what appears to be a typical LTCH case is simply not an equitable proposition. Again, with the 25 percent policy, there is no evidence available that this policy will only impact LTCH cases that are similar to IPPS cases or are cases that should have stayed in an acute care setting for a longer period of time. Instead, there is a very high risk that very typical LTCH cases (i.e. cases with much longer ALOS and higher costs than IPPS) will be extremely underpaid using an IPPS based payment.

The resulting overall LTC-PPS margins under the NPRM confirm what the component analyses indicate. The fall from 2.87 (RY 2007) to -0.84 (RY 2008 with NPRM SSO policy) indicates that the proposed rule does not provide adequate coverage for LTCH hospitals. Overall margins drop to -4.3 percent when including the impact of the 25 percent policy in RY 2008. As we noted earlier, we expect the losses to be incurred on 25 percent policy cases (over 6 percent of all LTCH cases) to be even greater than losses for SSO cases. Based on the evidence that LTCHs will not be able to significantly change their admitting procedures to avoid the detrimental financial impacts of the 25 percent policy, we estimate margins of close to -40 percent for these cases.

F. Limitations

There are several limitations to the analyses. We did not include the impact of the "interrupted stay" policy. An interrupted stay occurs when a LTCH patient is discharged to an ACH, inpatient rehabilitation facility (IRF), or skilled nursing facility (SNF) and then goes back to the LTCH within a specified period of time (9 days for an ACH, 27 days for an IRF, and 45 days for a SNF). One payment is made for these stays. Most likely this would have reduced the number of SSO and 25 percent cases. However, we do not expect the impact to be large and do not

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expect that our conclusions would have changed. We note that CMS does not model the impact of the interrupted stay policy in their impact analyses.

Similarly, there are also 5 percent thresholds established to discourage transfers between LTCHs and co-located providers. Under these thresholds, Medicare pays the LTCH for each discharge until 5 percent of discharges are made up of transfers from the LTCH to the co-located hospital and back (ACH, SNF, IRF, or psychiatric facility). After the 5 percent threshold is reached, these cases are paid as one LTCH admission rather than two. The 5 percent threshold is independent of the interrupted stay or 25 percent policies. Again, this would have the effect of reducing SSO and 25 percent policy cases. Like the interrupted stay policy it also will reduce payments for other cases and add to the complexity of the LTC-PPS. We do not believe this was incorporated in the CMS impact analysis either.

We also note that we did not include the RY 2007 25 percent policy in our base-line estimate of RY 2007 payments. This has the effect of overstating the negative decline of the 25 percent policy impact in our estimated RY 2008 payments. However we do believe that our model better estimates the expected impact to RY 2008 payments in comparison to the CMS estimates, which do not include the impact of the current law 25 percent policy in either of their RY 2007 or RY 2008 estimates.

Another limitation is that the claims data reflecting the 25 percent policy or current RY 2007 SSO policies are not available. This data would provide a more definitive understanding of if and how LTCHs would respond to these policies. The 25 percent policy began phase-in for co-located hospitals during FY 2006 cost reporting periods and will not be fully-phased in until FY 2008. Therefore, it will be several years before we can expect enough claims data to empirically verify LTCH behavioral impacts due to the 25 percent policy or IPPS-based SSO payment.

We also note that the most current available list of HwHs and LTCHs with satellites is not accurate. The list provided by CMS was found to be inaccurate and severely lagged in many instances according to NALTH board members.

One final limitation that we note is that there is a significant difference in the margins estimated from the case-level data and those estimated from the cost report data. This difference is not clearly understood.

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III. ALTERNATIVES

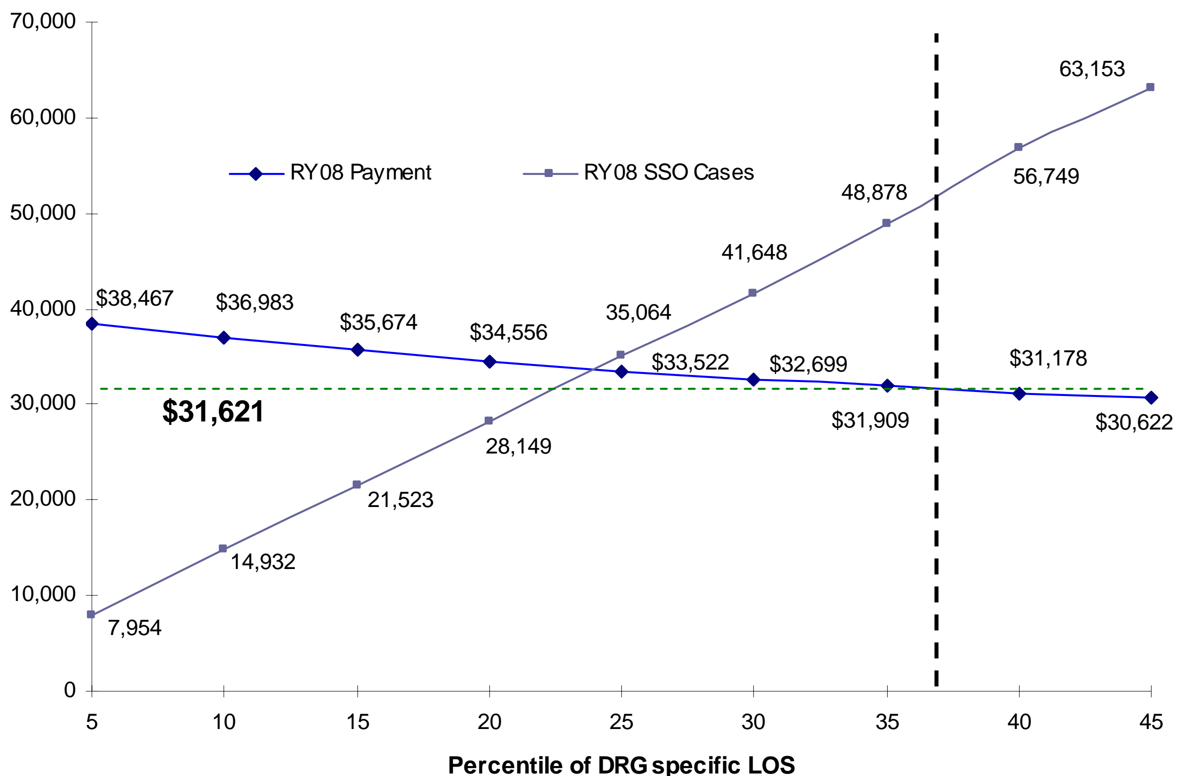
Based on the analysis throughout the report, we modeled several alternatives for the SSO and 25 percent policy policies.

A. Using the LTCH distribution of cases to select empirical outliers

One alternative to the SSO policy that CMS may consider is to use a percentile from the distribution of LTCH cases to determine the threshold defining SSOs. As discussed earlier, typically, outlier thresholds are used to identify cases that are more extreme than 95 to 99 percent of the cases. In this instance, we would choose the 1st through 5th percentile in order to select observations from the bottom tail of the distribution.

Exhibit II.A-1 shows the simulated impact on average payments and the number of SSO cases if CMS were to choose various percentiles as cut-offs from 5 percent to 40 percent in increments of five.

Exhibit III.A-1. Incremental Change to Payment and SSO Cases - Simulation of SSO Determined by Percentile of DRG LOS with SSO cases paid at Current Law



Note: Verticle black line marks point of budget neutrality w ith proposed SSO policy

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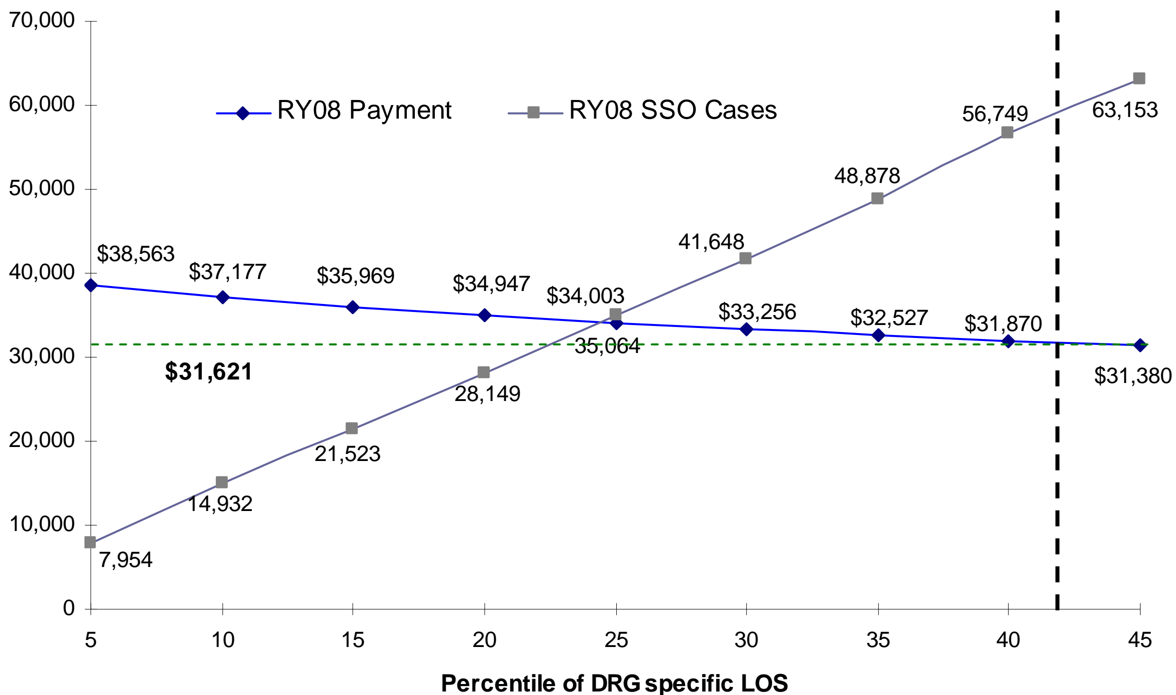
We see from ***Exhibit III.A-1*** that as the percentile used for the threshold increases, the number of cases that are impacted increase and the cost per case decreases dramatically. The vertical dashed black line denotes the percentile needed to obtain a SSO policy using percentiles based on the LTCH distribution that is budget neutral with the NPRM policy. For this simulation we assumed that SSO payments would be paid as they are under NPRM SSO rules.

Exhibit III.A -2 displays results assuming that we only use the cost-based option to pay SSO cases. Notice that the point of budget neutrality occurs at a higher percentile under an SSO policy based upon costs. Accordingly, the average payment is higher at every percentile in comparison to the simulation using the lesser of options under the current SSO policy.

Exhibit III.A -2. Incremental Change to Payment and SSO Cases - Simulation of SSO Determined by Percentile of DRG LOS with SSO cases paid at Cost



Note: Verticle black line marks point of budget neutrality w ith proposed SSO policy

This is an interesting result as currently the SSO cases ending up with the "cost" option being used for the final payments have lower per diems on average in comparison to the cases under the "per diem," "full LTC DRG," "blended rate," and "comp full IPPS" (hence, the "cost" option is the lesser of option. Note that the cost option makes up a slight majority of SSO cases under the current-SSO policy*)* and typically have longer average lengths of stay than the other cases as well (see ***Exhibit II.C.2-1)***. This seems to be an indication that the other options all act as very short-stay outlier options and that they are not doing very well at accounting for the extra costs that may be associated with initiating care. It also implies that the costs per diem are

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disproportionately higher in the cases that do not end up with the "cost" option in comparison to the relative difference in cases where the "cost" option is the lowest option. For this reason, the percentile where budget neutrality is reached with the current SSO policy is higher under the cost-only simulation.

Exhibit III.A -3 displays the impact to the Medicare budget under the two simulated alternatives for each of the percentiles. It is not until the 40th percentile, for the simulation using the NPRM SSO payment options, and the 45th percentile, for the cost-only option, where these alternatives begin to save money for Medicare in comparison to the proposed SSO policy.

Exhibit III.A -3. Impact of Alternative SSO policies to the Medicare Budget

Short Stay Outlier Payment Simulations	Medicare Costs/Savings Compared to the NPRM RY 2008 SSO Policy (in millions)	
Percent Trim	NPRM SSO	Cost-Only
5	$894.1	$906.7
10	$700.2	$725.6
15	$529.3	$567.8
20	$383.3	$434.4
25	$248.3	$311.1
30	$140.8	$213.5
35	$37.6	$118.4
40	-$57.8	$32.6
45	-$130.5	-$31.5

Percent Trim from the ALOS by LTCH DRG
Simulation 1 - SSO Cases paid under current law for RY2007 (minimum of 4 payment types)
Simulation 2 - SSO Cases paid at cost

B. Replacing the "5/6" rule with the IPPS ALOS plus 1 Standard Deviation

We also modeled an alternative SSO policy using the average LOS experienced in IPPS facilities plus one standard deviation as the outlier threshold. This would also identify cases that are more like outliers and less like the typical case in comparison to the 5/6 the LTCH geometric mean LOS threshold. Under this scenario, only 20,704 cases would be selected as SSO cases and the average payment would be $35,251 (assuming the proposed SSO payment methodology for RY 2008). This would lead to an increase in payment from the base-line estimate ($31,621) of 11.5 percent, leading to about $474 million in added Medicare costs in comparison to the NPRM SSO policy.

C. Removing Cases that end in Death from the SSO Policy

Another alternative we modeled for the SSO policy is to exclude the cases ending in death from the NPRM SSO policy. First, we eliminated all deaths from the SSO policy (11,152 cases). This resulted in an average payment amount of $34,316. This would lead to an increase in payment from the base-line estimate ($31,621) of 8.5 percent. Then we only excluded deaths from the VSSO policy (5,517 cases) which resulted in an average payment amount of $33,217. This would lead to an increase in payment of 5.0 percent.

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D. Identifying the same episode of care for 25 Percent Policy Cases

One alternative for the 25 percent policy is to further limit the cases subject to the rule by attempting to ensure treatment in the LTCH is really a continuation of care provided in the IPPS facility. One way to do this would be to check the discharging DRG from the host hospital and the admitting DRG in the LTCH to see if they are linked. We performed a crude simulation of this approach only assuming that same DRGs are linked. That is, the discharging DRG and the admitting LTCH DRG had to be the same in order to qualify for the 25 percent policy payment. Approximately, 20 percent of cases impacted by the 25 percent policy have the same DRGs. Hence this results in a -0.63 percent impact on payment as opposed to a -3.3 percent impact on payment. This approach may underestimate the number of related cases, as it is possible that a non-LTCH case may transfer into a LTCH categorized under a different DRG, but still be within the same episode of care.

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IV. CONCLUDING COMMENTS

The LTC PPS is no longer a prospective payment system in the sense that it is simple to understand and easy to administer and sets a series of prospective payments that on average reflect the production costs of LTCHs with average efficiency. The LTC PPS as proposed in the FY2008 NPRM is a system of exceptions not a system of averages. Before accounting for the 25 percent policy, 53 percent of cases are regular LTC PPS cases, 36 percent are short stay cases, and 11 percent are HCO cases under the FY2008 NPRM. Including the 25 percent policy expansion these figures are 50 percent, 34 percent, and 10 percent respectively with 6 percent being paid under the aggregate 25 percent policy. Our margin calculations excluding the 25 percent policy show LTCHs losing -0.84 percent and -4.31 percent including the 25 percent policy.

Our analysis indicates that neither the short stay outlier policies nor the 25 percent policy payments are intended to reflect LTCH costs as they are. At best these proposed policies pay for care as CMS argues it should be provided, that is, as an extension to an ACH stay. As we indicated, deaths cloud this CMS perspective as do the clinical realities of how LTCHs are organized and administered. In short, CMS is using the LTC PPS in a punitive fashion to form and shape which patients go to LTCHs, hence, overriding community referral patterns that are emerging between ACHs and LTCHs. Whether guiding clinical care content and location through payment rule regulation is an efficient method of changing our health care system remains to be seen.

MedPAC recommends facility and patient level criteria to better define LTCHs, on the grounds that this is the best way to target LTCH care to appropriate patients. MedPAC concludes that arbitrary rules may not achieve this end and we concur.

We also believe that the data analyzed in this report indicate that:

- Deaths should be eliminated from the short stay policy and given a full LTC-DRG based PPS payment. It is difficult for hospitals to predict when patients will die, end-of-life care can be very costly and resource intensive and acute care hospitals are paid a full DRG-PPS payment, so LTCHs should be paid at a full DRG-PPS payment as well.

- Similarly, SSO cases that result from patients exhausting their Medicare coverage should be excluded from the SSO policy. We find that these cases represent about one percent of all SSO cases. These SSO cases could result in significant underpayments to LTCHs when they admit very ill patients who have a long length of stay but who exhaust their limited Medicare day benefit prior to reaching SSO threshold points. A SSO policy that keeps all patients, whom CMS characterizes as short-stay patients for billing purposes, out of LTCHs, even though they may be long-stay patients, is irrational.

- CMS may want to consider thresholds for the SSO policy that better identify "outliers" and cases that are similar to IPPS cases. CMS contends that short stays in

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LTCHs are similar to IPPS cases. The thresholds for defining short stays is equal to 5/6 the geometric mean LOS for all LTCH cases for the particular DRG. In this rule, CMS now proposes to adopt another threshold that is supposed to identify LTCH cases that are similar to IPPS cases. CMS may consider replacing the 5/6 threshold, which is clinically arbitrary and empirically illogical for selecting "outliers" under a prospective payment system and use the proposed very short-stay outlier threshold, which is at least theoretically a better match for the objective. In most cases, it would also be a better statistical measure of an outlier as it would identify cases that were less like the median and at the same time more extreme.

- Alternatively, CMS may want to consider LTCH cases that are true short stay statistical outliers. For instance, CMS could use percentiles as thresholds that are based on the LTCH length of stay distributions by DRG. We have provided two simulations for this showing that the current-law threshold is not statistically justifiable. If CMS is going to use LOS as the only criteria for selected outliers, it should logically choose a threshold that better isolates cases that are dissimilar to the median and/or average case. For instance, the 5th percentile through 10th percentile from a statistical perspective better reflect the concept of outliers. The NPRM sets out payments that reflect about the 37th percentile paying at the NPRM's blend amounts and about the 42nd percentile paying at cost.

- CMS should not adopt the proposed expansion of the 25 percent policy to freestanding LTCHs (including grandfathered hospitals) and institute a standstill with regard to the phase-in of the 25 percent policy for co-located hospitals subject to the current phase-in of percentage thresholds. There currently is no data to gauge the behavioral changes by LTCHs in response to the rule and whether or not these changes align with the intended objectives of the policy.

- CMS should investigate ways of limiting cases impacted by the 25 percent policy to those that are a continuation of the same episode of care started in the IPPS hospital. We simulated the impact of one crude approach to doing this, which was to limit the 25 percent policy to those cases that have the same DRG between the ACH and LTCH. We calculate this to be approximately 20 percent of the current 25 percent policy cases.

- CMS should consider intensifying the review of the medical necessity of patients admitted to LTCHs and institute review of the medical necessity of the continued stay of Medicare patients. This recommendation builds on RTI's finding that some LTCHs may admit acutely ill patients who do not remain at a hospital level of care shortly after admission.[33] RTI indicated that some LTCHs may be retaining these patients as a way to meet the 25 day ALOS Medicare stay obligation of LTCHs. Under this recommendation where a LTCH did not correctly identify these patients

[33] RTI International, "LTCH Payment System Monitoring and Evaluation, Phase II Report," October 2006.

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and institute a search for a lower level of care placement, the related patient days would not be counted toward the 25 day ALOS and payment would be adjusted if the count of medically necessary days would result in a short stay payment. This recommendation is intended to offer a patient centered alternative to both the expansion and continued implementation of the 25 percent policy.

- Develop patient criteria that explicitly identify cases that CMS wants treated in LTCHs. The main intention of this recommendation is to replace the 25 percent policy and SSO policies with these criteria. Even though these policies may reduce Medicare costs, there is no reason to believe that these policies solely target cases that are inappropriate for LTCHs to treat. It is likely that properly defined and implemented patient criteria would do a better job in attaining all of the objectives CMS strives for with the 25 percent policy and SSO policies, without the detrimental effects of increasing the complexity of the LTC-PPS and reducing care options for its beneficiaries.

- LTCH payments should never be based on acute care payments. LTCHs provide a different type of care in comparison to acute care hospitals leading to different levels of intensity, resources and costs across the two types of facilities.

- CMS short-stay outlier rules have the illogical result that many cases defined as short stay under the policy have lengths of stay at approximately the same level as the overall length of stay defining LTCHs – 25 days. How can a stay reflecting the legislated length of stay of 25 days for LTCHs legitimately be defined as short stay outliers?

- Our analysis reveals that smaller hospitals tend to be at greater risk for financially detrimental effects due to the SSO and particularly the 25 percent policy policies. CMS should consider additional exceptions to the 25 percent policy for hospitals in rural areas as well as consider a low-volume adjustment similar to that which exists for acute care hospitals under IPPS.

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V. APPENDICES

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Appendix 1a. The Impact of Introducing the RY 2008 Proposed Federal Standard Rate

LTCH Classification		Number of LTCHs[1]	Number of LTCH Cases[2]	Average RY2007 Payment[3]	Average RY2008 Payment[4]	% Change (RY2007F - RY2008P)[5]
All Providers		369	130,599	$ 31,849.79	$ 32,090.37	0.76%
By Location						
	Large Urban	181	78,026	$ 33,114.52	$ 33,380.46	0.80%
	Other Urban	163	47,307	$ 30,462.79	$ 30,673.75	0.69%
	Rural	25	5,266	$ 25,570.41	$ 25,701.31	0.51%
By Ownership / Control						
	Voluntary	122	38,806	$ 32,004.82	$ 32,235.13	0.72%
	Proprietary	232	86,387	$ 31,931.51	$ 32,176.50	0.77%
	Government	15	5,406	$ 29,431.03	$ 29,674.85	0.83%
By Region						
	Midwest	84	24,073	$ 35,672.87	$ 35,961.41	0.81%
	Northeast	42	17,810	$ 29,767.73	$ 30,023.24	0.86%
	South	205	73,823	$ 29,835.21	$ 30,038.58	0.68%
	West	38	14,893	$ 38,146.07	$ 38,475.72	0.86%
By Bed Size						
	1: 1-24	41	7,683	$ 29,916.73	$ 30,113.18	0.66%
	2: 25-49	197	51,891	$ 31,903.12	$ 32,144.42	0.76%
	3: 50-74	57	23,132	$ 32,449.38	$ 32,690.15	0.74%
	4: 75-124	42	23,800	$ 32,585.21	$ 32,833.10	0.76%
	5: 125-199	18	12,379	$ 31,409.34	$ 31,637.49	0.73%
	6: 200 - 299	10	7,799	$ 31,283.20	$ 31,549.01	0.85%
	7: 300+	4	3,915	$ 29,444.36	$ 29,705.39	0.89%

[1]CMS-1529-P LTCH Impact file and March 2006 Provider of Services data

[2]December 2006 update of FY2005 MedPAR

[3]RY2007 calculated under current law in effect for LTCH discharges after 10/1/2006 for LTC-PPS and IPPS area wage index and DRG weights

[4]RY2008 calculated with proposed standard amount and high-cost outlier updates, market basket inflation update and current law for RY2007 in effect for LTCH discharges after 10/1/2006 for LTC-PPS and IPPS area wage index and DRG weights.

[5] CMS estimates that the update to the standard amounts in isolation of the area wage adjustment under current law with the SSO policy which includes "IPPS comparable payments" on average would increase payments to LTCHs by 0.6%.

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Appendix 1b. The Impact of Introducing the RY 2008 Proposed Federal Standard Rate and Wage Index

LTCH Classification		Number of LTCHs[1]	Number of LTCH Cases[2]	Average RY2007 Payment[3]	Average RY2008 Payment[4]	% Change (RY2007F - RY2008P)[5]
All Providers		369	130,599	$ 31,849.79	$ 31,956.14	0.33%
By Location						
	Large Urban	181	78,026	$ 33,114.52	$ 33,386.06	0.82%
	Other Urban	163	47,307	$ 30,462.79	$ 30,351.97	-0.36%
	Rural	25	5,266	$ 25,570.41	$ 25,180.27	-1.53%
By Ownership / Control						
	Voluntary	122	38,806	$ 32,004.82	$ 32,046.29	0.13%
	Proprietary	232	86,387	$ 31,931.51	$ 32,068.53	0.43%
	Government	15	5,406	$ 29,431.03	$ 29,513.08	0.28%
By Region						
	Midwest	84	24,073	$ 35,672.87	$ 35,924.86	0.71%
	Northeast	42	17,810	$ 29,767.73	$ 29,971.74	0.69%
	South	205	73,823	$ 29,835.21	$ 29,723.33	-0.37%
	West	38	14,893	$ 38,146.07	$ 38,981.98	2.19%
By Bed Size						
	1: 1-24	41	7,683	$ 29,916.73	$ 29,882.46	-0.11%
	2: 25-49	197	51,891	$ 31,903.12	$ 31,919.77	0.05%
	3: 50-74	57	23,132	$ 32,449.38	$ 32,530.53	0.25%
	4: 75-124	42	23,800	$ 32,585.21	$ 32,742.39	0.48%
	5: 125-199	18	12,379	$ 31,409.34	$ 31,601.30	0.61%
	6: 200 - 299	10	7,799	$ 31,283.20	$ 31,789.39	1.62%
	7: 300+	4	3,915	$ 29,444.36	$ 29,788.40	1.17%

[1]CMS-1529-P LTCH Impact file and March 2006 Provider of Services data

[2]December 2006 update of FY2005 MedPAR

[3]RY2007 calculated under current law in effect for LTCH discharges after 10/1/2006 for LTC-PPS and IPPS area wage index and DRG weights

[4]RY2008 calculated with proposed standard amount and high-cost outlier updates, market basket inflation update, area wage adjustment update and current law for RY2007 in effect for LTCH discharges after 10/1/2006 for LTC-PPS and IPPS area wage index and DRG weights.

[5] CMS indicates that in absence of the SSO approach, all LTCHs, on average, would experience a 0.3 percent increase in estimated payments from the RY2007 LTCH PPS to the RY2008 LTCH PPS for all proposed payment rate and policy changes presented in the preamble of the proposed rule (72 FR 4839).

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Appendix 1c. The Impact of Introducing the RY 2008 Proposed Federal Standard Rate, Wage Index, and Short-Stay Outlier Policy

LTCH Classification		Number of LTCHs[1]	Number of LTCH Cases[2]	Average RY2007 Payment[3]	Average RY2008 Payment[4]	% Change (RY2007F - RY2008P)[5]
All Providers		369	130,599	$ 31,849.79	$ 31,621.30	-0.72%
By Location						
	Large Urban	181	78,026	$ 33,114.52	$ 33,057.61	-0.17%
	Other Urban	163	47,307	$ 30,462.79	$ 29,999.20	-1.52%
	Rural	25	5,266	$ 25,570.41	$ 24,911.82	-2.58%
By Ownership / Control						
	Voluntary	122	38,806	$ 32,004.82	$ 31,681.08	-1.01%
	Proprietary	232	86,387	$ 31,931.51	$ 31,739.99	-0.60%
	Government	15	5,406	$ 29,431.03	$ 29,295.67	-0.46%
By Region						
	Midwest	84	24,073	$ 35,672.87	$ 35,541.80	-0.37%
	Northeast	42	17,810	$ 29,767.73	$ 29,727.35	-0.14%
	South	205	73,823	$ 29,835.21	$ 29,394.87	-1.48%
	West	38	14,893	$ 38,146.07	$ 38,585.31	1.15%
By Bed Size						
	1: 1-24	41	7,683	$ 29,916.73	$ 29,526.41	-1.30%
	2: 25-49	197	51,891	$ 31,903.12	$ 31,546.26	-1.12%
	3: 50-74	57	23,132	$ 32,449.38	$ 32,151.70	-0.92%
	4: 75-124	42	23,800	$ 32,585.21	$ 32,434.88	-0.46%
	5: 125-199	18	12,379	$ 31,409.34	$ 31,349.84	-0.19%
	6: 200 - 299	10	7,799	$ 31,283.20	$ 31,555.45	0.87%
	7: 300+	4	3,915	$ 29,444.36	$ 29,636.81	0.65%

[1]CMS-1529-P LTCH Impact file and March 2006 Provider of Services data

[2]December 2006 update of FY2005 MedPAR

[3]RY2007 calculated under current law in effect for LTCH discharges after 10/1/2006 for LTC-PPS and IPPS area wage index and DRG weights

[4]RY2008 calculated with proposed standard amount and high-cost outlier updates, market basket inflation update, area wage adjustment update, and the SSO approach with current law for RY2007 in effect for LTCH discharges after 10/1/2006 for LTC-PPS and IPPS area wage index and DRG weights.

[5] CMS indicates that all LTCHs, on average, would experience a -0.7 percent decrease in estimated payments from the RY2007 LTCH PPS to the RY2008 LTCH PPS for all proposed payment rate and policy changes presented in the preamble of the proposed rule (72 FR 4839) inclusive of the SSO approach for very short stay outliers.

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Appendix 1d. The Impact of Introducing the RY 2008 Proposed Federal Standard Rate, Wage Index, Short-Stay Outlier Policy, and 25 Percent Policy

LTCH Classification		Number of LTCHs[1]	Number of LTCH Cases[2]	Average RY2007 Payment[3]	Average RY2008 Payment[4]	% Change (RY2007F - RY2008P)
All Providers		369	130,599	$ 31,849.79	$ 30,570.16	-4.02%
By Location						
	Large Urban	181	78,026	$ 33,114.52	$ 32,129.90	-2.97%
	Other Urban	163	47,307	$ 30,462.79	$ 28,721.87	-5.71%
	Rural	25	5,266	$ 25,570.41	$ 24,063.62	-5.89%
By Ownership / Control						
	Voluntary	122	38,806	$ 32,004.82	$ 30,253.71	-5.47%
	Proprietary	232	86,387	$ 31,931.51	$ 30,818.16	-3.49%
	Government	15	5,406	$ 29,431.03	$ 28,878.80	-1.88%
By Region						
	Midwest	84	24,073	$ 35,672.87	$ 34,492.77	-3.31%
	Northeast	42	17,810	$ 29,767.73	$ 28,553.39	-4.08%
	South	205	73,823	$ 29,835.21	$ 28,246.23	-5.33%
	West	38	14,893	$ 38,146.07	$ 38,160.91	0.04%
By Bed Size						
	1: 1-24	41	7,683	$ 29,916.73	$ 28,299.35	-5.41%
	2: 25-49	197	51,891	$ 31,903.12	$ 29,923.08	-6.21%
	3: 50-74	57	23,132	$ 32,449.38	$ 31,635.08	-2.51%
	4: 75-124	42	23,800	$ 32,585.21	$ 31,795.36	-2.42%
	5: 125-199	18	12,379	$ 31,409.34	$ 30,490.65	-2.92%
	6: 200 - 299	10	7,799	$ 31,283.20	$ 30,866.11	-1.33%
	7: 300+	4	3,915	$ 29,444.36	$ 29,524.71	0.27%

[1]CMS-1529-P LTCH Impact file and March 2006 Provider of Services data

[2]December 2006 update of FY2005 MedPAR

[3]RY2007 calculated under current law in effect for LTCH discharges after 10/1/2006 for LTC-PPS and IPPS area wage index and DRG weights

[4]RY2008 calculated with proposed standard amount and high-cost outlier updates, market basket inflation update, area wage adjustment update, and the SSO approach with current law for RY2007 in effect for LTCH discharges after 10/1/2006 for LTC-PPS and IPPS area wage index and DRG weights and the impact of the proposed expansion of the "25% rule" to include freestanding LTC hospitals.

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Appendix 2. SSO Discharges as a Percent of Total Cases by DRG (Top 50 DRGs ranked by number of SSO Cases)

Rank	DRG	DGR Name	Total Cases	Short Stay Outlier Cases	Short Stay as a Percent of Total Cases
1	565*	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT 96+ HOURS	15685	6300	40.17%
2	87	PULMONARY EDEMA & RESPIRATORY FAILURE	6014	2520	41.90%
3	271	SKIN ULCERS	6646	2263	34.05%
4	79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	6013	2235	37.17%
5	88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	5336	2109	39.52%
6	89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	5170	1936	37.45%
7	576	SEPTICEMIA W/O MV 96+ HOURS AGE >17	5058	1878	37.13%
8	466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	5006	1833	36.62%
9	249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	5022	1557	31.00%
10	127	HEART FAILURE & SHOCK	3909	1479	37.84%
11	462	REHABILITATION	4223	1432	33.91%
12	12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	4852	1399	28.83%
13	263	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	3968	1132	28.53%
14	316	RENAL FAILURE	2536	989	39.00%
15	418	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	2404	808	33.61%
16	277	CELLULITIS AGE >17 W CC	2069	745	36.01%
17	144	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1968	742	37.70%
18	76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	1862	712	38.24%
19	238	OSTEOMYELITIS	2104	642	30.51%
20	320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	1937	642	33.14%
21	452	COMPLICATIONS OF TREATMENT W CC	1829	632	34.55%
22	188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1577	629	39.89%
23	430	PSYCHOSES	1782	555	31.14%
24	130	PERIPHERAL VASCULAR DISORDERS W CC	1449	501	34.58%
25	296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	1288	461	35.79%
26	468	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1350	451	33.41%
27	182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	1166	433	37.14%
28	578	O. R. PROCEDURE W PDX EXC POSTOPERATIVE OR POST-TRAUMATIC INFECTION	1254	396	31.58%
29	294	DIABETES AGE >35	1298	379	29.20%
30	465	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	924	353	38.20%
31	542	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	967	306	31.64%
32	217	WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS	943	283	30.01%
33	126	ACUTE & SUBACUTE ENDOCARDITIS	723	254	35.13%
34	461	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	795	237	29.81%
35	269	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	738	218	29.54%
36	34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	533	194	36.40%
37	256	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	531	190	35.78%
38	120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	604	188	31.13%
39	82	RESPIRATORY NEOPLASMS	354	178	50.28%
40	331	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	485	176	36.29%
41	101	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	458	174	37.99%
42	204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	433	163	37.64%
43	423	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	362	161	44.48%
44	243	MEDICAL BACK PROBLEMS	494	157	31.78%
45	477	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	487	148	30.39%
46	561	NON-BACTERIAL INFECTIONS OF NERVOUS SYSTEM EXCEPT VIRAL MENINGITIS	459	146	31.81%
47	315	OTHER KIDNEY & URINARY TRACT PROCEDURES	394	144	36.55%
48	180	G.I. OBSTRUCTION W CC	342	142	41.52%
49	172	DIGESTIVE MALIGNANCY W CC	291	133	45.70%
50	99	RESPIRATORY SIGNS & SYMPTOMS W CC	295	132	44.75%

*Note that DRG 565 also includes DRG 566 cases when crosswalking V.21 (FY2005 data) to V.23 cannot determine which proportion of DRG 475 should be DRG 566.

Source: Lewin Group analysis of CY 2005 MedPAR data

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Appendix 3. Comparison of Resources by DRG for IPPS and LPPS for Short Stay Outliers

	IPPS				LPPS					
DRG	Total IPPS Cases	IPPS Average Covered Days	IPPS Average Cost	IPPS Mortality	Total LPPS Cases	LPPS Average Covered Days	LPPS Average Cost	LPPS Mortality	Difference IPPS to LPPS Covered Days	Difference IPPS to LPPS Cost
Case Weighted by LTC Distribution	**10,924,417**	**7.4**	**12,296**	**0.09**	**47,107**	**12.8**	**18,003**	**0.24**	**73%**	**46%**
1	24,641	9	26,327	0.10	2	29	57,878	-	212%	120%
7	15,063	9	19,337	0.03	81	22	29,082	0.23	145%	50%
9	1,876	6	10,578	0.09	39	19	24,199	0.10	207%	129%
10	20,071	6	8,960	0.07	44	12	13,998	0.36	100%	56%
11	3,158	4	6,480	0.02	6	10	11,527	-	174%	78%
12	87,949	8	7,078	0.01	1,399	12	13,355	0.15	55%	89%
13	7,651	5	6,667	0.00	43	11	10,399	0.02	141%	56%
14	281,210	5	8,731	0.10	114	12	12,609	0.24	115%	44%
15	20,315	4	6,865	0.02	14	11	13,210	0.21	161%	92%
16	17,708	6	9,277	0.04	78	10	13,947	0.29	64%	50%
17	3,018	3	5,217	0.00	4	6	11,613	0.50	96%	123%
18	33,736	5	7,184	0.01	113	14	14,036	0.08	178%	95%
19	8,499	3	5,300	0.00	12	10	8,698	-	208%	64%
21	2,217	6	10,959	0.02	11	11	12,467	0.09	84%	14%
22	3,168	5	8,518	0.01	7	9	11,081	0.29	79%	30%
23	11,286	4	5,966	0.03	21	12	12,417	0.10	203%	108%
27	5,991	5	10,727	0.35	12	16	19,274	0.17	256%	80%
28	20,066	6	9,823	0.09	63	13	15,090	0.19	130%	54%
29	6,586	3	5,441	0.03	6	11	11,010	-	243%	102%
31	4,991	4	7,106	0.02	2	10	6,795	-	176%	-4%
32	1,863	2	4,617	0.00	1	2	1,303	-	-4%	-72%
34	28,509	5	7,456	0.05	194	11	14,263	0.15	123%	91%
35	8,091	3	5,116	0.00	12	10	8,252	0.08	198%	61%
44	1,320	5	5,503	0.00	4	10	9,965	0.25	111%	81%
45	2,780	3	5,657	0.00	1	11	10,329	-	274%	83%
46	4,000	4	5,766	0.01	9	12	10,159	-	182%	76%
64	3,345	6	9,448	0.09	39	12	16,618	0.23	105%	76%
65	40,876	3	4,482	0.00	6	7	5,044	-	139%	13%
67	379	4	6,247	0.01	1	18	28,770	1.00	403%	361%
68	19,164	4	5,047	0.01	19	11	12,901	0.05	198%	156%
69	5,214	3	3,708	0.00	5	9	7,378	-	214%	99%
72	1,348	3	5,665	0.01	2	8	10,131	-	150%	79%
73	10,028	4	6,218	0.02	38	11	14,849	0.18	170%	139%
75	48,040	9	22,038	0.05	16	16	26,862	0.13	76%	22%
76	48,323	10	19,742	0.08	712	24	43,062	0.27	137%	118%
77	2,120	4	8,776	0.01	1	7	17,315	-	62%	97%
78	49,815	6	9,074	0.04	107	10	11,785	0.14	76%	30%
79	161,198	8	11,255	0.11	2,235	11	15,438	0.31	43%	37%
80	7,229	5	6,521	0.04	46	10	11,508	0.17	101%	76%
82	63,992	7	10,184	0.14	178	10	13,041	0.46	48%	28%
83	7,090	5	7,502	0.02	1	14	12,448	-	192%	66%
85	22,384	6	9,002	0.04	79	9	11,029	0.30	45%	23%
87	96,997	6	9,951	0.14	2,520	11	15,888	0.33	77%	60%
88	429,948	5	6,349	0.01	2,109	10	12,297	0.16	107%	94%
89	558,048	5	7,431	0.04	1,936	10	12,952	0.25	85%	74%
90	43,952	4	4,469	0.01	41	7	8,678	0.10	106%	94%
92	16,640	6	8,646	0.06	99	9	11,213	0.31	50%	30%
93	1,454	4	5,399	0.03	7	7	8,239	0.43	85%	53%
94	13,660	6	8,408	0.03	37	10	12,141	0.22	84%	44%
95	1,580	3	4,502	0.00	1	4	5,169	-	24%	15%
96	60,441	4	5,318	0.00	61	9	12,128	0.18	124%	128%
97	27,148	3	3,946	0.00	8	8	7,402	-	133%	88%
99	21,573	3	5,364	0.02	132	10	13,844	0.36	226%	158%

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Appendix 3 cont'd. Comparison of Resources by DRG for IPPS and LPPS for Short Stay Outliers

DRG	IPPS				LPPS				Difference IPPS to LPPS Covered Days	Difference IPPS to LPPS Cost
	Total IPPS Cases	IPPS Average Covered Days	IPPS Average Cost	IPPS Mortality	Total LPPS Cases	LPPS Average Covered Days	LPPS Average Cost	LPPS Mortality		
100	6,470	2	4,068	0.00	5	7	10,784	0.20	250%	165%
101	23,491	4	6,460	0.02	174	11	14,049	0.20	163%	117%
102	4,941	2	4,166	0.00	4	8	7,646	-	213%	84%
110	57,653	8	29,192	0.12	2	13	19,976	0.50	67%	-32%
113	34,721	12	20,961	0.06	65	22	32,800	0.14	82%	56%
114	7,989	8	11,943	0.02	21	17	21,692	0.19	107%	82%
117	5,348	4	10,043	0.01	1	4	8,178	1.00	-4%	-19%
118	7,657	3	11,747	0.00	1	13	20,432	-	335%	74%
119	967	5	10,601	0.02	1	3	4,958	-	-42%	-53%
120	33,522	9	16,598	0.05	188	18	22,755	0.11	115%	37%
121	150,617	6	11,229	-	37	9	10,768	-	48%	-4%
122	54,770	3	7,046	-	5	13	9,867	-	302%	40%
123	29,635	5	11,138	1.00	27	6	10,319	1.00	36%	-7%
124	120,500	4	10,477	0.01	7	19	31,899	-	356%	204%
126	5,458	10	17,882	0.11	254	13	17,755	0.25	23%	-1%
127	670,849	5	7,357	0.04	1,479	10	12,333	0.30	99%	68%
128	4,267	5	5,155	0.01	7	8	10,625	-	61%	106%
129	3,539	2	7,746	0.88	1	9	7,145	-	266%	-8%
130	88,313	5	6,839	0.04	501	12	12,770	0.12	120%	87%
131	23,083	4	4,100	0.01	14	12	11,000	0.07	221%	168%
132	102,170	3	4,578	0.01	78	9	10,536	0.10	233%	130%
133	5,960	2	4,267	0.00	3	15	15,052	-	588%	253%
134	40,542	3	4,507	0.00	25	10	9,696	0.12	230%	115%
135	7,279	4	6,962	0.04	48	11	13,863	0.13	153%	99%
136	954	3	4,779	0.00	1	12	14,487	-	334%	203%
138	207,025	4	6,082	0.02	117	10	11,694	0.19	160%	92%
139	74,372	2	3,856	0.00	6	6	5,805	-	140%	51%
140	31,713	2	3,899	0.00	4	8	8,862	-	257%	127%
141	123,944	3	5,486	0.00	12	9	8,705	0.08	179%	59%
142	49,593	2	4,344	0.00	9	10	8,683	-	315%	100%
143	239,288	2	4,173	0.00	4	6	5,757	-	184%	38%
144	105,617	6	9,528	0.04	742	11	13,288	0.16	94%	39%
145	5,763	2	4,438	0.01	14	8	10,488	0.07	232%	136%
146	10,387	10	19,287	0.02	1	21	62,137	1.00	120%	222%
150	23,017	10	20,353	0.04	2	26	49,690	0.50	145%	144%
152	5,041	8	14,186	0.02	1	3	5,889	-	-61%	-58%
157	8,354	5	9,716	0.01	3	10	15,626	-	82%	61%
159	19,236	5	10,751	0.01	1	2	11,331	-	-59%	5%
160	11,998	3	6,486	0.00	1	10	14,360	-	294%	121%
170	18,044	10	21,295	0.09	54	19	27,860	0.09	86%	31%
172	33,749	7	10,408	0.10	133	10	12,123	0.38	45%	16%
173	2,301	3	5,531	0.02	7	8	8,112	0.14	118%	47%
174	262,219	5	7,552	0.03	72	10	11,316	0.21	116%	50%
175	30,062	3	4,254	0.00	4	4	2,861	0.25	26%	-33%
176	14,691	5	8,081	0.02	22	9	14,593	0.23	90%	81%
177	7,682	4	6,723	0.01	7	9	10,990	-	105%	63%
179	14,724	6	7,916	0.01	22	10	13,694	0.18	90%	73%
180	91,880	5	7,047	0.04	142	11	14,550	0.31	107%	106%
181	25,383	3	4,202	0.00	3	7	8,735	-	129%	108%
182	298,386	4	6,197	0.01	433	11	14,000	0.21	146%	126%
183	82,215	3	4,300	0.00	19	7	6,016	0.05	141%	40%
185	6,313	4	6,557	0.02	16	11	13,476	-	152%	106%
188	94,171	5	8,175	0.04	629	12	16,641	0.23	124%	104%
189	13,238	3	4,476	0.01	19	11	11,702	0.11	257%	161%
191	10,947	12	30,913	0.06	4	21	48,123	-	78%	56%
195	2,846	10	21,875	0.04	1	22	25,942	-	111%	19%
197	16,439	9	18,621	0.03	2	20	25,789	-	121%	38%
199	1,539	9	17,068	0.06	1	19	40,579	-	121%	138%

Appendix 3 cont'd. Comparison of Resources by DRG for IPPS and LPPS for Short Stay Outliers

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	IPPS				LPPS					
DRG	Total IPPS Cases	IPPS Average Covered Days	IPPS Average Cost	IPPS Mortality	Total LPPS Cases	LPPS Average Covered Days	LPPS Average Cost	LPPS Mortality	Difference IPPS to LPPS Covered Days	Difference IPPS to LPPS Cost
201	2,742	13	28,590	0.11	12	18	29,515	0.17	38%	3%
202	27,661	6	10,019	0.09	65	9	10,736	0.31	51%	7%
203	33,086	6	10,128	0.13	72	9	10,319	0.40	39%	2%
204	69,558	5	8,135	0.02	163	11	14,316	0.12	111%	76%
205	32,948	6	9,092	0.08	81	10	12,768	0.35	86%	40%
206	2,059	4	5,630	0.01	3	16	13,800	-	331%	145%
207	38,663	5	8,860	0.02	37	9	10,057	0.19	70%	14%
208	9,612	3	5,292	0.00	2	13	14,207	-	336%	168%
210	126,754	7	13,772	0.03	11	27	35,178	0.18	308%	155%
213	9,518	9	14,659	0.03	39	20	27,084	0.10	133%	85%
216	20,020	5	13,401	0.01	6	26	28,676	-	406%	114%
217	15,734	11	21,033	0.02	283	22	26,663	0.09	88%	27%
218	30,107	5	12,517	0.01	7	21	21,387	0.14	301%	71%
223	12,688	3	8,737	0.00	3	21	27,161	-	579%	211%
224	9,967	2	6,267	-	1	9	12,682	-	384%	102%
225	6,278	5	9,195	0.00	15	20	19,781	-	289%	115%
226	6,827	6	11,929	0.02	29	21	26,377	0.14	238%	121%
228	2,688	4	8,942	0.00	1	15	15,719	-	273%	76%
230	2,471	5	10,508	0.01	6	20	27,493	-	291%	162%
233	18,500	6	14,259	0.01	26	22	31,021	0.04	250%	118%
236	43,964	5	5,563	0.04	21	16	15,146	0.14	230%	172%
237	1,931	4	4,791	0.00	1	10	10,179	-	170%	112%
238	9,855	8	9,940	0.02	642	14	15,650	0.10	77%	57%
239	40,903	6	7,898	0.04	57	11	12,298	0.16	84%	56%
240	13,111	6	10,388	0.04	53	11	13,900	0.11	81%	34%
241	2,895	4	5,047	0.00	1	14	14,776	-	288%	193%
242	2,767	6	8,238	0.02	129	14	15,853	0.09	119%	92%
243	101,904	4	5,778	0.01	157	11	10,166	0.08	144%	76%
244	19,071	5	5,602	0.00	27	12	11,625	-	144%	108%
245	6,950	4	4,082	0.00	14	10	8,776	-	149%	115%
246	1,529	4	4,639	0.00	3	15	12,360	-	293%	166%
247	21,637	3	4,498	0.00	29	8	7,346	-	145%	63%
248	16,611	5	6,564	0.01	99	11	12,394	0.10	133%	89%
249	14,750	4	5,760	0.01	1,557	13	12,953	0.06	192%	125%
250	4,191	4	5,215	0.01	1	8	5,280	-	111%	1%
251	2,088	3	3,624	0.00	1	6	3,604	-	121%	-1%
253	25,091	5	5,884	0.02	14	12	10,074	0.14	155%	71%
254	10,126	3	3,504	0.00	4	8	6,319	-	171%	80%
256	7,725	5	6,211	0.02	190	11	13,691	0.18	120%	120%
257	13,319	3	6,768	0.00	1	30	53,591	-	1098%	692%
258	11,570	2	5,451	0.00	1	1	14,046	-	-40%	158%
262	602	4	6,874	0.00	2	21	27,054	-	365%	294%
263	22,572	10	13,731	0.02	1,132	21	25,579	0.20	115%	86%
264	3,914	6	7,650	0.00	40	17	17,298	0.08	188%	126%
265	4,146	6	12,214	0.01	25	19	24,384	0.04	206%	100%
266	2,325	3	6,880	-	2	13	12,791	-	330%	86%
268	1,015	3	9,585	0.00	2	17	30,541	-	390%	219%
269	11,118	8	12,463	0.02	218	19	24,263	0.18	150%	95%
270	2,612	3	6,144	-	5	14	14,046	-	294%	129%
271	21,879	7	7,251	0.02	2,263	13	14,942	0.27	95%	106%
272	6,131	6	7,636	0.03	21	12	13,628	0.19	112%	78%
273	1,280	4	4,430	0.00	2	7	5,574	-	94%	26%
274	2,281	6	8,498	0.16	17	11	12,054	0.53	80%	42%
276	1,639	4	5,300	0.01	7	12	10,172	-	163%	92%
277	120,095	5	6,226	0.01	745	11	12,123	0.06	115%	95%
278	34,217	4	3,957	0.00	75	10	9,139	0.01	156%	131%
280	19,421	4	5,498	0.01	47	11	10,932	0.09	189%	99%
281	6,606	3	3,751	0.00	7	9	8,636	0.14	221%	130%

Appendix 3 cont'd. Comparison of Resources by DRG for IPPS and LPPS for Short Stay Outliers

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DRG	IPPS				LPPS				Difference IPPS to LPPS Covered Days	Difference IPPS to LPPS Cost
	Total IPPS Cases	IPPS Average Covered Days	IPPS Average Cost	IPPS Mortality	Total LPPS Cases	LPPS Average Covered Days	LPPS Average Cost	LPPS Mortality		
283	6,854	4	5,664	0.01	48	12	13,583	0.02	164%	140%
284	1,892	3	3,375	0.00	4	12	9,652	-	314%	186%
285	8,071	9	15,108	0.01	38	18	22,074	0.03	87%	46%
287	5,465	9	12,889	0.02	119	20	24,029	0.07	127%	86%
288	11,307	3	14,551	0.00	6	5	16,299	0.33	30%	12%
292	7,615	10	18,819	0.04	28	19	27,223	0.07	102%	45%
294	98,395	4	5,605	0.01	379	12	12,753	0.07	186%	128%
295	4,382	3	5,547	0.00	4	12	13,146	-	243%	137%
296	249,150	5	5,935	0.03	461	10	12,013	0.27	123%	102%
297	43,004	3	3,615	0.01	12	7	8,612	-	146%	138%
299	1,573	5	7,808	0.01	4	10	13,906	0.25	117%	78%
300	21,883	6	8,013	0.02	31	10	10,784	0.23	76%	35%
301	3,978	3	4,620	0.00	4	9	7,186	-	173%	56%
304	14,194	8	18,061	0.02	3	14	15,200	0.33	71%	-16%
306	5,830	5	9,489	0.01	2	20	26,832	-	265%	183%
308	6,728	6	12,480	0.02	1	20	13,880	-	234%	11%
310	25,490	4	8,746	0.01	2	16	16,377	-	252%	87%
315	34,877	6	15,232	0.02	144	20	28,442	0.10	212%	87%
316	205,556	6	9,061	0.07	989	11	14,415	0.26	78%	59%
317	2,701	3	5,742	0.02	22	12	14,438	0.14	259%	151%
318	6,019	6	8,918	0.09	25	11	15,224	0.40	82%	71%
320	226,630	5	6,115	0.02	642	11	12,001	0.15	128%	96%
321	32,390	3	4,136	0.00	35	9	7,801	0.03	168%	89%
323	20,515	3	6,076	0.00	3	10	8,896	0.33	220%	46%
325	9,992	4	4,836	0.01	6	6	4,737	0.17	59%	-2%
331	57,231	5	8,092	0.02	176	10	13,349	0.23	95%	65%
332	4,197	3	4,847	0.00	3	5	5,222	-	79%	8%
336	28,220	3	6,319	0.00	1	24	20,026	-	659%	217%
339	1,237	5	9,334	0.00	4	11	16,823	-	106%	80%
341	3,151	3	9,609	0.00	5	20	31,896	0.20	579%	232%
344	2,367	3	9,244	0.01	1	13	31,005	-	388%	235%
345	1,400	5	9,500	0.01	7	19	27,526	0.14	263%	190%
346	4,066	6	7,764	0.10	10	13	17,955	0.40	130%	131%
347	254	3	4,019	0.06	1	9	8,723	-	252%	117%
348	4,302	4	5,181	0.01	4	14	11,634	-	254%	125%
350	7,319	4	5,553	0.01	25	11	11,792	0.04	152%	112%
352	1,188	4	5,564	0.01	16	12	14,488	0.13	188%	160%
356	22,319	2	5,698	0.00	1	2	9,976	-	11%	75%
359	28,775	2	6,146	0.00	1	3	11,195	-	35%	82%
365	1,635	8	15,128	0.04	2	20	29,741	-	164%	97%
366	4,751	6	9,132	0.11	37	10	14,503	0.38	66%	59%
367	461	3	4,437	0.03	2	7	5,485	1.00	113%	24%
368	4,189	6	8,220	0.02	22	10	11,589	0.09	54%	41%
369	3,815	3	4,612	0.00	1	18	19,128	-	470%	315%
394	2,788	7	14,518	0.03	1	20	23,814	1.00	188%	64%
395	116,761	4	6,063	0.01	79	10	11,881	0.13	147%	96%
397	16,590	5	11,367	0.04	23	9	18,791	0.26	85%	65%
398	19,037	6	9,274	0.03	18	11	16,889	0.22	93%	82%
399	1,673	3	4,992	0.01	1	7	2,983	-	115%	-40%
401	6,556	11	21,625	0.08	8	16	30,642	0.25	49%	42%
403	32,187	8	13,678	0.12	112	11	15,501	0.29	40%	13%
404	3,765	4	6,813	0.03	7	5	6,417	0.57	21%	-6%
406	2,414	9	20,912	0.06	1	26	26,807	-	189%	28%
408	2,052	8	16,614	0.05	3	22	38,752	-	184%	133%
409	1,768	6	9,916	0.04	79	13	15,890	0.28	120%	60%
410	30,794	4	8,394	0.01	35	16	22,644	0.40	351%	170%
413	5,841	7	9,849	0.15	21	8	13,690	0.48	27%	39%
418	30,198	6	8,113	0.01	808	12	15,303	0.11	105%	89%

Appendix 3 cont'd. Comparison of Resources by DRG for IPPS and LPPS for Short Stay Outliers

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DRG	IPPS				LPPS				Difference IPPS to LPPS Covered Days	Difference IPPS to LPPS Cost
	Total IPPS Cases	IPPS Average Covered Days	IPPS Average Cost	IPPS Mortality	Total LPPS Cases	LPPS Average Covered Days	LPPS Average Cost	LPPS Mortality		
419	17,900	4	6,409	0.01	6	5	5,819	0.17	27%	-9%
420	3,071	3	4,426	0.00	1	4	3,142	-	30%	-29%
421	13,325	4	5,759	0.01	25	10	13,453	0.16	158%	134%
423	9,161	8	13,784	0.07	161	11	18,774	0.22	44%	36%
424	2,007	14	15,979	0.01	9	21	23,180	0.11	48%	45%
425	17,375	4	5,002	0.00	7	11	10,629	-	149%	113%
426	17,493	6	4,502	0.00	11	10	6,817	-	57%	51%
427	5,978	6	4,309	0.00	2	7	3,904	-	27%	-9%
428	2,885	8	5,981	0.00	4	11	9,363	-	37%	57%
429	56,674	9	7,018	0.01	73	12	12,163	0.05	36%	73%
430	347,528	10	6,957	0.00	555	13	7,827	0.01	29%	13%
431	1,695	9	5,903	0.00	2	11	12,826	0.50	23%	117%
432	512	5	5,408	0.00	1	7	3,884	-	45%	-28%
439	1,773	8	15,354	0.01	18	25	28,196	-	217%	84%
440	5,223	8	13,571	0.01	131	21	26,862	0.09	168%	98%
441	690	3	7,871	0.00	1	9	12,133	-	168%	54%
442	18,634	8	18,983	0.04	52	20	36,295	0.04	143%	91%
444	6,057	4	5,540	0.01	47	10	10,760	0.13	164%	94%
445	2,293	3	3,885	0.00	6	13	10,028	-	346%	158%
449	41,494	4	6,495	0.02	7	12	11,649	-	234%	79%
452	28,902	5	7,987	0.02	632	13	17,056	0.15	167%	114%
453	5,415	3	3,985	0.00	24	9	9,939	-	255%	149%
454	4,782	4	6,314	0.04	9	10	11,685	0.11	149%	85%
461	5,959	13	17,265	0.01	237	19	25,949	0.09	49%	50%
462	287,367	12	10,465	0.00	1,432	11	11,151	0.10	-7%	7%
463	33,944	4	5,293	0.01	98	11	11,237	0.12	169%	112%
464	7,801	3	3,826	0.00	20	13	10,712	0.05	339%	180%
465	269	6	6,164	0.00	353	11	12,058	0.08	71%	96%
466	2,252	8	7,239	0.01	1,833	11	12,189	0.10	37%	68%
467	1,195	3	3,931	0.05	16	7	9,707	0.13	136%	147%
468	52,150	12	27,695	0.08	451	22	38,206	0.23	83%	38%
471	16,731	5	23,317	0.00	1	22	100,949	-	373%	333%
473	8,934	12	25,581	0.24	15	15	24,435	0.47	21%	-4%
476	2,856	10	14,887	0.02	9	23	36,201	-	140%	143%
477	28,286	8	14,734	0.03	148	20	30,521	0.22	148%	107%
487	4,961	6	14,911	0.16	11	13	15,383	0.36	109%	3%
488	828	16	39,074	0.12	2	19	32,813	0.50	16%	-16%
489	13,894	8	14,245	0.08	126	10	14,789	0.19	22%	4%
490	5,409	5	8,403	0.03	32	9	12,025	0.09	81%	43%
491	22,770	3	13,558	0.00	1	21	14,870	-	613%	10%
492	4,419	13	26,767	0.07	1	9	12,254	-	-30%	-54%
493	61,078	6	13,278	0.01	4	17	22,673	-	184%	71%
496	3,725	8	49,794	0.02	1	18	62,396	-	118%	25%
497	31,323	5	28,581	0.00	3	21	37,213	-	281%	30%
499	35,334	4	10,436	0.00	3	9	27,664	-	131%	165%
501	3,185	9	17,922	0.02	7	20	25,413	0.14	110%	42%
505	189	6	22,791	0.84	3	14	17,285	0.67	137%	-24%
506	990	15	33,194	0.06	6	17	20,904	0.33	17%	-37%
508	675	7	10,873	0.04	14	15	15,385	0.07	105%	41%
509	159	5	6,677	0.03	1	12	9,683	-	152%	45%
510	1,834	6	10,427	0.03	13	11	13,257	0.15	85%	27%
511	649	4	5,749	0.01	1	14	14,369	-	287%	150%
515	58,322	4	38,847	0.01	1	20	79,547	-	436%	105%
519	12,593	4	19,708	0.01	2	13	47,255	-	180%	140%
521	39,139	6	5,446	0.00	15	10	9,796	0.07	74%	80%
523	21,308	4	3,339	0.00	1	7	8,334	-	70%	150%
524	109,562	3	5,246	0.00	8	7	7,785	-	126%	48%
531	4,924	9	23,787	0.03	12	13	34,401	-	52%	45%

Appendix 3 cont'd. Comparison of Resources by DRG for IPPS and LPPS for Short Stay Outliers

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DRG	IPPS Total IPPS Cases	IPPS Average Covered Days	IPPS Average Cost	IPPS Mortality	LPPS Total LPPS Cases	LPPS Average Covered Days	LPPS Average Cost	LPPS Mortality	Difference IPPS to LPPS Covered Days	Difference IPPS to LPPS Cost
532	2,858	3	11,555	-	3	12	42,590	-	241%	269%
533	46,587	4	11,220	0.01	7	15	29,621	0.29	340%	164%
537	8,995	6	13,707	0.01	19	24	29,975	0.11	285%	119%
538	5,496	3	8,047	0.00	2	20	43,776	-	604%	444%
539	5,147	10	23,632	0.07	1	15	20,626	1.00	48%	-13%
541	25,192	39	133,617	0.27	106	33	76,118	0.61	-15%	-43%
542	23,427	29	77,782	0.23	306	23	56,494	0.62	-18%	-27%
551	53,935	6	22,174	0.02	2	23	25,282	-	276%	14%
553	39,338	9	21,587	0.06	10	18	29,136	0.20	101%	35%
554	77,404	5	15,390	0.01	5	20	22,345	-	265%	45%
561	6,506	10	19,760	0.07	146	10	14,313	0.16	6%	-28%
562	63,619	4	7,316	0.02	45	12	13,335	0.11	178%	82%
563	27,421	3	4,824	0.00	11	10	9,897	-	228%	105%
565*	120,632	10	24,911	0.33	6,300	15	30,474	0.47	44%	22%
567	27,304	13	30,053	0.10	7	17	27,390	0.14	34%	-9%
569	133,594	12	24,881	0.07	13	19	38,167	0.23	60%	53%
576	289,556	7	12,317	0.20	1,878	11	14,947	0.33	50%	21%
578	56,031	13	28,068	0.12	396	20	28,964	0.14	50%	3%

*Note that DRG 565 also includes DRG 566 cases when crosswalking V.21 (FY2005 data) to V.23 cannot determine which proportion of DRG 475 should be DRG 566.

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Appendix 4. Comparison of Resources by DRG for IPPS and LPPS for Very Short Stay Outliers

	IPPS				LTC-PPS					
DRG	Total IPPS Cases	IPPS Average Covered Days	IPPS Average Cost	IPPS Mortality	Total LTC-PPS Cases	LTC-PPS Average Covered Days	LTC-PPS Average Cost	LTC-PPS Mortality	Difference IPPS to LTC-PPS Covered Days	Difference IPPS to LTC-PPS Cost
Case Weighted by LTC Distribution	**9,068,038**	**10.27**	**14,508**	**0.13**	**14,605**	**8.43**	**16,357**	**0.38**	**-18%**	**13%**
7	15,063	12	19,334	0.03	5	13	18,630	0.40	5%	-4%
9	1,876	6	10,575	0.09	1	6	9,402	-	0%	-11%
10	20,071	4	8,959	0.07	5	6	12,931	0.40	40%	44%
12	87,949	8	7,061	0.01	311	5	7,230	0.26	-37%	2%
13	7,651	2	6,664	0.00	5	6	7,708	0.20	200%	16%
14	281,210	1	8,731	0.10	18	5	9,470	0.28	378%	8%
15	20,315	3	6,864	0.02	3	3	3,913	0.33	11%	-43%
16	17,708	9	9,264	0.04	28	6	9,173	0.43	-35%	-1%
18	33,736	5	7,182	0.01	16	4	7,467	0.25	-14%	4%
21	2,217	4	10,957	0.02	2	3	5,938	0.50	-25%	-46%
22	3,168	7	8,514	0.01	2	4	10,175	1.00	-43%	20%
23	11,286	3	5,965	0.03	2	3	6,387	-	0%	7%
28	20,066	3	9,820	0.09	10	5	8,334	0.30	67%	-15%
34	28,509	6	7,450	0.05	37	5	7,484	0.30	-19%	0%
44	1,320	2	5,499	0.00	1	2	9,209	1.00	0%	67%
64	3,345	4	9,429	0.09	12	7	11,216	0.42	81%	19%
68	19,164	4	5,046	0.01	1	4	16,740	-	0%	232%
73	10,028	5	6,215	0.02	6	4	6,984	0.17	-23%	12%
75	48,040	1	22,036	0.05	6	9	19,964	-	799%	-9%
76	48,323	10	19,696	0.08	143	12	27,773	0.43	21%	41%
77	2,120	7	8,773	0.01	1	7	17,315	-	0%	97%
78	49,815	5	9,070	0.04	23	6	8,717	0.30	16%	-4%
79	161,198	8	11,197	0.11	957	8	12,089	0.44	-4%	8%
80	7,229	1	6,509	0.04	15	5	6,144	0.33	363%	-6%
82	63,992	3	10,175	0.14	75	7	10,879	0.49	123%	7%
85	22,384	3	8,992	0.04	33	6	9,207	0.45	90%	2%
87	96,997	8	9,880	0.14	889	6	10,402	0.50	-26%	5%
88	429,948	5	6,342	0.01	520	5	7,153	0.27	-2%	13%
89	558,048	4	7,424	0.04	593	5	8,045	0.41	30%	8%
90	43,952	2	4,469	0.01	9	3	4,400	0.11	61%	-2%
92	16,640	8	8,633	0.06	37	6	9,201	0.54	-25%	7%
93	1,454	5	5,384	0.03	4	4	6,143	0.50	-25%	14%
94	13,660	9	8,403	0.03	10	7	10,795	0.30	-26%	28%
95	1,580	4	4,493	0.00	1	4	5,169	-	0%	15%
96	60,441	6	5,318	0.00	10	5	7,630	0.30	-22%	43%
97	27,148	5	3,946	0.00	1	5	5,880	-	0%	49%
99	21,573	2	5,360	0.02	23	2	4,904	0.61	17%	-9%
101	23,491	3	6,454	0.02	30	4	6,776	0.37	38%	5%
113	34,721	20	20,956	0.06	19	14	24,925	0.16	-32%	19%
114	7,989	7	11,940	0.02	5	8	13,910	0.40	9%	16%
120	33,522	12	16,589	0.05	35	12	21,225	0.26	2%	28%
121	150,617	10	11,229	-	9	7	12,096	-	-33%	8%
123	29,635	7	11,137	1.00	8	5	7,564	1.00	-36%	-32%
126	5,458	4	17,602	0.11	103	10	18,327	0.30	139%	4%
127	670,849	3	7,354	0.04	407	5	8,544	0.44	82%	16%
128	4,267	1	5,153	0.01	3	4	7,979	-	299%	55%
130	88,313	8	6,833	0.04	115	5	7,562	0.21	-35%	11%
131	23,083	3	4,100	0.01	1	3	5,737	1.00	0%	40%
132	102,170	3	4,578	0.01	16	3	4,387	0.19	2%	-4%
135	7,279	2	6,958	0.04	7	3	6,541	0.43	57%	-6%
138	207,025	2	6,082	0.02	23	3	5,486	0.35	67%	-10%
139	74,372	3	3,856	0.00	2	3	4,036	-	0%	5%
144	105,617	8	9,518	0.04	185	6	9,562	0.28	-27%	0%

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Appendix 4 cont'd. Comparison of Resources by DRG for IPPS and LPPS for Very Short Stay Outliers

	IPPS				LTC-PPS					
DRG	Total IPPS Cases	IPPS Average Covered Days	IPPS Average Cost	IPPS Mortality	Total LTC-PPS Cases	LTC-PPS Average Covered Days	LTC-PPS Average Cost	LTC-PPS Mortality	Difference IPPS to LTC-PPS Covered Days	Difference IPPS to LTC-PPS Cost
152	5,041	3	14,184	0.02	1	3	5,889	-	0%	-58%
157	8,354	9	9,715	0.01	1	9	10,666	-	0%	10%
159	19,236	2	10,750	0.01	1	2	11,331	-	0%	5%
170	18,044	6	21,287	0.09	15	12	23,984	0.13	105%	13%
172	33,749	6	10,395	0.10	53	6	9,779	0.49	7%	-6%
173	2,301	2	5,529	0.02	2	2	3,800	-	-25%	-31%
174	262,219	5	7,551	0.03	17	5	7,530	0.29	-7%	0%
175	30,062	2	4,254	0.00	1	2	3,023	1.00	0%	-29%
176	14,691	7	8,079	0.02	7	5	11,207	0.29	-33%	39%
179	14,724	9	7,913	0.01	7	6	8,643	0.29	-32%	9%
180	91,880	2	7,044	0.04	49	5	7,647	0.49	127%	9%
181	25,383	3	4,202	0.00	1	3	3,181	-	0%	-24%
182	298,386	6	6,195	0.01	66	4	6,689	0.36	-32%	8%
183	82,215	4	4,300	0.00	4	4	4,577	-	-6%	6%
185	6,313	5	6,556	0.02	3	5	10,578	-	7%	61%
188	94,171	4	8,164	0.04	146	5	9,594	0.35	27%	18%
189	13,238	4	4,475	0.01	1	4	4,330	1.00	0%	-3%
191	10,947	7	30,912	0.06	1	7	23,585	-	0%	-24%
201	2,742	18	28,558	0.11	7	18	36,402	0.14	-2%	27%
202	27,661	7	10,014	0.09	16	6	9,854	0.38	-21%	-2%
203	33,086	4	10,124	0.13	22	6	9,212	0.45	61%	-9%
204	69,558	7	8,130	0.02	43	5	9,533	0.21	-22%	17%
205	32,948	3	9,088	0.08	20	5	7,689	0.60	65%	-15%
207	38,663	1	8,859	0.02	9	5	7,573	0.33	411%	-15%
213	9,518	14	14,653	0.03	4	12	19,068	0.25	-12%	30%
217	15,734	20	20,987	0.02	59	15	26,601	0.17	-23%	27%
226	6,827	4	11,927	0.02	1	4	20,882	-	0%	75%
230	2,471	4	10,506	0.01	1	4	7,212	-	0%	-31%
233	18,500	9	14,259	0.01	1	9	12,530	-	0%	-12%
236	43,964	3	5,563	0.04	4	5	4,332	0.25	50%	-22%
238	9,855	3	9,772	0.02	198	8	10,773	0.14	149%	10%
239	40,903	9	7,896	0.04	12	7	8,428	0.08	-25%	7%
240	13,111	9	10,380	0.04	15	8	10,631	0.07	-16%	2%
242	2,767	8	8,167	0.02	33	7	9,262	0.18	-12%	13%
243	101,904	2	5,776	0.01	26	5	5,569	0.23	148%	-4%
244	19,071	7	5,601	0.00	3	5	10,045	-	-29%	79%
245	6,950	3	4,081	0.00	3	3	3,064	-	-11%	-25%
247	21,637	4	4,498	0.00	2	4	4,176	-	-12%	-7%
248	16,611	6	6,559	0.01	19	5	7,471	0.26	-24%	14%
249	14,750	6	5,733	0.01	110	4	6,383	0.15	-30%	11%
253	25,091	6	5,884	0.02	3	6	6,488	0.67	6%	10%
256	7,725	3	6,175	0.02	42	5	8,904	0.33	66%	44%
263	22,572	13	13,636	0.02	235	12	16,814	0.34	-10%	23%
264	3,914	8	7,646	0.00	4	7	8,349	-	-12%	9%
265	4,146	9	12,213	0.01	1	9	12,159	-	0%	0%
269	11,118	13	12,430	0.02	39	10	15,807	0.31	-23%	27%
271	21,879	7	7,069	0.02	661	6	8,485	0.39	-12%	20%
272	6,131	9	7,632	0.03	6	6	6,811	0.17	-37%	-11%
274	2,281	9	8,491	0.16	5	6	8,008	0.60	-36%	-6%
276	1,639	7	5,296	0.01	2	7	9,034	-	0%	71%
277	120,095	7	6,220	0.01	148	6	8,021	0.11	-16%	29%
278	34,217	5	3,957	0.00	7	4	4,564	-	-20%	15%
280	19,421	1	5,496	0.01	5	3	4,503	0.20	200%	-18%
283	6,854	6	5,660	0.01	9	4	5,282	-	-28%	-7%
285	8,071	14	15,095	0.01	11	12	17,513	-	-15%	16%
287	5,465	12	12,857	0.02	16	12	16,791	0.19	-4%	31%
292	7,615	10	18,815	0.04	5	12	23,043	0.20	20%	22%

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Appendix 4 cont'd. Comparison of Resources by DRG for IPPS and LPPS for Very Short Stay Outliers

	IPPS				LTC-PPS					
DRG	Total IPPS Cases	IPPS Average Covered Days	IPPS Average Cost	IPPS Mortality	Total LTC-PPS Cases	LTC-PPS Average Covered Days	LTC-PPS Average Cost	LTC-PPS Mortality	Difference IPPS to LTC-PPS Covered Days	Difference IPPS to LTC-PPS Cost
294	98,395	5	5,604	0.01	35	4	6,214	0.14	-17%	11%
296	249,150	1	5,933	0.03	111	5	7,302	0.38	359%	23%
297	43,004	2	3,615	0.01	1	2	13,513	-	0%	274%
299	1,573	7	7,795	0.01	1	7	8,755	-	0%	12%
300	21,883	7	8,012	0.02	8	7	8,266	0.38	-7%	3%
301	3,978	2	4,620	0.00	1	2	2,813	-	0%	-39%
304	14,194	9	18,061	0.02	1	9	16,428	1.00	0%	-9%
315	34,877	11	15,230	0.02	11	9	19,836	0.36	-21%	30%
316	205,556	8	9,051	0.07	308	6	9,469	0.40	-28%	5%
317	2,701	3	5,742	0.02	1	3	7,015	-	0%	22%
318	6,019	9	8,902	0.09	8	6	11,635	0.38	-32%	31%
320	226,630	3	6,113	0.02	100	5	7,274	0.30	68%	19%
321	32,390	5	4,136	0.00	2	3	2,434	-	-40%	-41%
325	9,992	1	4,835	0.01	2	3	3,196	0.50	200%	-34%
331	57,231	6	8,087	0.02	53	5	9,719	0.32	-13%	20%
339	1,237	8	9,325	0.00	1	8	27,128	-	0%	191%
346	4,066	4	7,761	0.10	2	7	16,316	0.50	62%	110%
350	7,319	2	5,552	0.01	2	5	10,045	-	125%	81%
352	1,188	2	5,558	0.01	2	3	6,151	-	25%	11%
359	28,775	3	6,146	0.00	1	3	11,195	-	0%	82%
366	4,751	4	9,116	0.11	14	7	13,501	0.43	82%	48%
368	4,189	9	8,209	0.02	9	8	10,619	0.22	-12%	29%
395	116,761	4	6,063	0.01	12	4	5,987	-	2%	-1%
397	16,590	2	11,365	0.04	7	5	16,722	0.43	157%	47%
398	19,037	7	9,273	0.03	4	6	11,582	0.25	-21%	25%
401	6,556	13	21,620	0.08	3	11	23,132	0.33	-13%	7%
403	32,187	13	13,667	0.12	46	8	15,239	0.39	-36%	12%
404	3,765	2	6,810	0.03	2	4	7,603	1.00	100%	12%
409	1,768	6	9,874	0.04	18	7	10,674	0.28	16%	8%
413	5,841	3	9,840	0.15	11	6	11,150	0.55	103%	13%
418	30,198	3	8,063	0.01	220	6	9,281	0.19	96%	15%
419	17,900	5	6,409	0.01	1	5	9,484	-	0%	48%
421	13,325	3	5,758	0.01	4	4	7,361	-	33%	28%
423	9,161	2	13,717	0.07	73	8	15,706	0.32	292%	15%
424	2,007	17	15,959	0.01	3	16	23,401	-	-8%	47%
425	17,375	3	5,001	0.00	1	3	4,462	-	0%	-11%
426	17,493	5	4,501	0.00	3	5	4,090	-	7%	-9%
428	2,885	10	5,978	0.00	1	10	9,228	-	0%	54%
429	56,674	6	7,017	0.01	11	4	6,078	-	-26%	-13%
430	347,528	11	6,955	0.00	122	8	5,168	0.02	-32%	-26%
431	1,695	9	5,901	0.00	1	9	4,851	-	0%	-18%
440	5,223	7	13,549	0.01	9	9	16,343	-	30%	21%
442	18,634	9	18,977	0.04	8	8	31,734	-	-7%	67%
444	6,057	3	5,531	0.01	9	4	5,624	0.33	37%	2%
449	41,494	4	6,495	0.02	1	4	6,653	-	0%	2%
452	28,902	5	7,967	0.02	99	4	9,258	0.21	-11%	16%
453	5,415	3	3,984	0.00	4	3	6,133	-	-8%	54%
454	4,782	2	6,312	0.04	3	5	5,615	0.33	133%	-11%
461	5,959	7	17,244	0.01	10	7	13,863	-	-7%	-20%
462	287,367	5	10,434	0.00	982	9	9,286	0.11	77%	-11%
463	33,944	6	5,291	0.01	15	4	6,580	0.20	-33%	24%
464	7,801	2	3,826	0.00	1	2	2,461	-	0%	-36%
465	269	1	5,300	0.00	42	4	4,858	0.12	157%	-8%
466	2,252	7	5,982	0.01	431	5	6,586	0.18	-29%	10%
467	1,195	3	3,926	0.05	3	3	3,857	-	-11%	-2%
468	52,150	12	27,644	0.08	135	16	35,723	0.30	29%	29%
473	8,934	14	25,562	0.24	11	16	29,219	0.36	16%	14%
476	2,856	14	14,884	0.02	1	14	13,085	-	0%	-12%

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Appendix 4 cont'd. Comparison of Resources by DRG for IPPS and LPPS for Very Short Stay Outliers

	IPPS				LTC-PPS					
DRG	Total IPPS Cases	IPPS Average Covered Days	IPPS Average Cost	IPPS Mortality	Total LTC-PPS Cases	LTC-PPS Average Covered Days	LTC-PPS Average Cost	LTC-PPS Mortality	Difference IPPS to LTC-PPS Covered Days	Difference IPPS to LTC-PPS Cost
477	28,286	11	14,725	0.03	28	10	20,380	0.43	-10%	38%
487	4,961	7	14,909	0.16	2	5	10,380	1.00	-36%	-30%
488	828	18	38,972	0.12	2	19	32,813	0.50	6%	-16%
489	13,894	11	14,203	0.08	56	8	15,211	0.34	-27%	7%
490	5,409	7	8,393	0.03	10	6	9,766	0.20	-21%	16%
499	35,334	5	10,435	0.00	1	5	8,963	-	0%	-14%
501	3,185	13	17,920	0.02	1	13	23,302	-	0%	30%
505	189	9	22,782	0.84	1	9	19,536	1.00	0%	-14%
506	990	5	33,143	0.06	4	15	22,213	0.50	202%	-33%
508	675	2	10,851	0.04	2	7	8,252	-	247%	-24%
510	1,834	7	10,423	0.03	3	6	7,443	-	-10%	-29%
521	39,139	7	5,446	0.00	7	7	7,015	-	-6%	29%
524	109,562	4	5,246	0.00	1	4	4,978	-	0%	-5%
531	4,924	7	23,749	0.03	8	12	38,465	-	75%	62%
537	8,995	3	13,706	0.01	1	3	25,077	-	0%	83%
539	5,147	15	23,628	0.07	1	15	20,626	1.00	0%	-13%
541	25,192	16	133,434	0.27	34	31	100,176	0.68	96%	-25%
542	23,427	12	77,162	0.23	203	22	63,518	0.70	85%	-18%
553	39,338	9	21,587	0.06	1	9	22,808	-	0%	6%
561	6,506	14	19,593	0.07	64	9	16,495	0.25	-37%	-16%
562	63,619	7	7,316	0.02	4	7	10,215	0.50	-4%	40%
563	27,421	1	4,824	0.00	1	1	1,777	-	0%	-63%
565*	120,632	21	24,259	0.33	3,431	12	30,305	0.53	-40%	25%
567	27,304	9	30,053	0.10	1	9	25,194	-	0%	-16%
569	133594	9	24,879	0.07	8	14	32,893	0.13	57%	32%
576	289556	9	12,296	0.20	628	7	11,928	0.50	-27%	-3%
578	56031	26	28,012	0.12	155	19	34,243	0.21	-28%	22%

*Note that DRG 565 also includes DRG 566 cases when crosswalking V.21 (FY2005 data) to V.23 cannot determine which proportion of DRG 475 should be DRG 566.

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Appendix 5. Comparison of Resources by DRG for IPPS and LPPS for 25 percent Policy Cases

	IPPS				LTC-PPS					
DRG	Total IPPS Cases	IPPS Average Covered Days	IPPS Average Cost	IPPS Mortality	Total LTC-PPS Cases	LTC-PPS Average Covered Days	LTC-PPS Average Cost	LTC-PPS Mortality	Difference IPPS to LTC-PPS Covered Days	Difference IPPS to LTC-PPS Cost
Case Weighted by LTC Distribution	**10,207,507**	**7.08**	**11,097**	**0.07**	**8,172**	**24.47**	**30,507**	**0.11**	**246%**	**175%**
7	15,063	9	19,337	0.03	22	43	44,121	0.14	381%	128%
8	3,435	3	13,288	0.00	1	24	18,990	-	810%	43%
10	20,071	6	8,960	0.07	9	19	18,445	0.33	230%	106%
11	3,158	4	6,480	0.02	3	26	50,741	-	634%	683%
12	87,949	8	7,078	0.01	317	25	25,880	0.06	226%	266%
13	7,651	5	6,667	0.00	8	19	17,082	-	317%	156%
14	281,210	5	8,731	0.10	31	29	29,421	0.06	435%	237%
15	20,315	4	6,865	0.02	1	19	22,238	-	366%	224%
16	17,708	6	9,277	0.04	11	19	23,895	0.27	198%	158%
18	33,736	5	7,184	0.01	26	23	25,119	-	368%	250%
19	8,499	3	5,300	0.00	2	20	13,385	-	495%	153%
21	2,217	6	10,959	0.02	5	24	23,388	-	308%	113%
22	3,168	5	8,518	0.01	1	9	8,314	-	84%	-2%
23	11,286	4	5,966	0.03	3	20	16,437	-	400%	176%
27	5,991	5	10,727	0.35	2	58	85,573	-	1153%	698%
28	20,066	6	9,823	0.09	14	20	23,004	0.21	266%	134%
29	6,586	3	5,441	0.03	3	20	15,640	-	534%	187%
31	4,991	4	7,106	0.02	1	8	5,000	-	121%	-30%
34	28,509	5	7,456	0.05	43	24	29,020	0.12	397%	289%
35	8,091	3	5,116	0.00	1	14	12,761	-	335%	149%
64	3,345	6	9,448	0.09	10	28	42,172	0.10	358%	346%
68	19,164	4	5,047	0.01	1	24	43,883	-	539%	770%
73	10,028	4	6,218	0.02	10	18	21,872	-	323%	252%
75	48,040	9	22,038	0.05	2	38	71,079	-	314%	223%
76	48,323	10	19,742	0.08	75	38	69,341	0.23	273%	251%
77	2,120	4	8,776	0.01	1	45	45,551	-	944%	419%
78	49,815	6	9,074	0.04	24	21	21,888	0.13	250%	141%
79	161,198	8	11,255	0.11	381	21	27,588	0.15	171%	145%
80	7,229	5	6,521	0.04	8	22	21,734	-	331%	233%
82	63,992	7	10,184	0.14	31	22	29,869	0.29	239%	193%
85	22,384	6	9,002	0.04	22	21	22,360	0.09	252%	148%
87	96,997	6	9,951	0.14	303	22	30,397	0.22	264%	205%
88	429,948	5	6,349	0.01	278	19	23,739	0.09	303%	274%
89	558,048	5	7,431	0.04	295	20	24,326	0.15	261%	227%
90	43,952	4	4,469	0.01	6	17	20,693	-	364%	363%
92	16,640	6	8,646	0.06	25	22	22,735	0.12	277%	163%
94	13,660	6	8,408	0.03	5	13	13,163	-	137%	57%
96	60,441	4	5,318	0.00	12	14	15,501	0.08	223%	191%
97	27,148	3	3,946	0.00	3	21	26,074	-	551%	561%
99	21,573	3	5,364	0.02	18	22	30,504	0.11	618%	469%
101	23,491	4	6,460	0.02	23	21	22,377	-	410%	246%
110	57,653	8	29,192	0.12	1	34	41,090	-	338%	41%
113	34,721	12	20,961	0.06	15	36	49,078	-	196%	134%
114	7,989	8	11,943	0.02	6	23	28,308	0.17	183%	137%
117	5,348	4	10,043	0.01	1	25	22,861	-	500%	128%
120	33,522	9	16,598	0.05	40	30	38,536	0.08	247%	132%
121	150,617	6	11,229	-	5	20	21,537	-	234%	92%
122	54,770	3	7,046	-	2	18	16,437	-	450%	133%
123	29,635	5	11,138	1.00	2	13	16,501	1.00	166%	48%
124	120,500	4	10,477	0.01	3	39	50,867	-	823%	386%
126	5,458	10	17,882	0.11	51	27	31,934	0.10	160%	79%
127	670,849	5	7,357	0.04	315	20	22,071	0.19	298%	200%
128	4,267	5	5,155	0.01	3	25	26,422	-	401%	413%

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Appendix 5 cont'd. Comparison of Resources by DRG for IPPS and LPPS for 25 percent Policy Cases

	IPPS				LTC-PPS					
DRG	Total IPPS Cases	IPPS Average Covered Days	IPPS Average Cost	IPPS Mortality	Total LTC-PPS Cases	LTC-PPS Average Covered Days	LTC-PPS Average Cost	LTC-PPS Mortality	Difference IPPS to LTC-PPS Covered Days	Difference IPPS to LTC-PPS Cost
129	3,539	2	7,746	0.88	1	9	7,145	-	266%	-8%
130	88,313	5	6,839	0.04	94	21	21,911	0.10	305%	220%
131	23,083	4	4,100	0.01	2	35	44,779	-	852%	992%
132	102,170	3	4,578	0.01	10	19	19,369	0.20	590%	323%
134	40,542	3	4,507	0.00	7	26	20,660	-	746%	358%
135	7,279	4	6,962	0.04	11	20	23,767	0.09	371%	241%
138	207,025	4	6,082	0.02	29	22	23,343	0.03	470%	284%
140	31,713	2	3,899	0.00	1	20	31,666	-	767%	712%
141	123,944	3	5,486	0.00	1	28	41,184	-	730%	651%
142	49,593	2	4,344	0.00	1	18	16,294	-	638%	275%
143	239,288	2	4,173	0.00	1	24	25,089	-	1085%	501%
144	105,617	6	9,528	0.04	157	20	23,134	0.09	261%	143%
145	5,763	2	4,438	0.01	2	14	11,601	-	451%	161%
150	23,017	10	20,353	0.04	1	29	74,940	1.00	178%	268%
170	18,044	10	21,295	0.09	5	34	34,516	0.20	232%	62%
172	33,749	7	10,408	0.10	26	26	34,496	0.15	292%	231%
173	2,301	3	5,531	0.02	1	14	9,171	-	304%	66%
174	262,219	5	7,552	0.03	18	21	28,068	0.11	358%	272%
175	30,062	3	4,254	0.00	1	25	30,045	-	798%	606%
176	14,691	5	8,081	0.02	2	19	21,817	-	272%	170%
179	14,724	6	7,916	0.01	7	20	27,350	0.14	266%	246%
180	91,880	5	7,047	0.04	27	22	28,632	0.22	325%	306%
181	25,383	3	4,202	0.00	1	3	3,181	-	-6%	-24%
182	298,386	4	6,197	0.01	83	22	28,693	0.11	392%	363%
183	82,215	3	4,300	0.00	1	13	9,824	-	366%	128%
185	6,313	4	6,557	0.02	4	26	26,493	-	508%	304%
188	94,171	5	8,175	0.04	114	23	28,800	0.14	326%	252%
189	13,238	3	4,476	0.01	3	15	18,361	0.33	408%	310%
191	10,947	12	30,913	0.06	1	29	83,980	-	146%	172%
195	2,846	10	21,875	0.04	1	22	25,942	-	111%	19%
199	1,539	9	17,068	0.06	1	19	40,579	-	121%	138%
201	2,742	13	28,590	0.11	2	26	28,640	0.50	98%	0%
202	27,661	6	10,019	0.09	9	22	24,641	0.33	264%	146%
203	33,086	6	10,128	0.13	12	17	21,634	0.42	169%	114%
204	69,558	5	8,135	0.02	32	24	31,251	0.03	355%	284%
205	32,948	6	9,092	0.08	16	17	24,828	0.13	202%	173%
207	38,663	5	8,860	0.02	10	18	21,021	0.10	247%	137%
210	126,754	7	13,772	0.03	1	60	89,257	-	816%	548%
213	9,518	9	14,659	0.03	7	38	51,121	0.14	342%	249%
216	20,020	5	13,401	0.01	2	29	29,013	-	457%	116%
217	15,734	11	21,033	0.02	79	34	43,010	0.06	196%	104%
218	30,107	5	12,517	0.01	5	29	27,072	-	453%	116%
225	6,278	5	9,195	0.00	4	22	21,155	-	333%	130%
226	6,827	6	11,929	0.02	5	26	31,578	0.20	331%	165%
233	18,500	6	14,259	0.01	8	38	59,081	0.13	515%	314%
235	4,911	5	5,708	0.04	2	32	21,284	-	556%	273%
236	43,964	5	5,563	0.04	4	23	19,000	-	381%	242%
238	9,855	8	9,940	0.02	150	30	32,296	0.05	281%	225%
239	40,903	6	7,898	0.04	22	22	21,153	-	271%	168%
240	13,111	6	10,388	0.04	18	24	31,253	0.06	279%	201%
242	2,767	6	8,238	0.02	47	31	32,772	0.02	393%	298%
243	101,904	4	5,778	0.01	20	22	24,016	0.05	391%	316%
244	19,071	5	5,602	0.00	2	10	10,331	-	95%	84%
245	6,950	4	4,082	0.00	2	19	13,306	-	374%	226%
248	16,611	5	6,564	0.01	23	22	22,477	0.13	354%	242%
249	14,750	4	5,760	0.01	490	23	23,138	0.02	421%	302%
253	25,091	5	5,884	0.02	1	6	4,736	1.00	33%	-20%
256	7,725	5	6,211	0.02	38	21	23,692	0.11	335%	281%

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Appendix 5 cont'd. Comparison of Resources by DRG for IPPS and LPPS for 25 percent Policy Cases

DRG	IPPS				LTC-PPS				Difference IPPS to LTC-PPS Covered Days	Difference IPPS to LTC-PPS Cost
	Total IPPS Cases	IPPS Average Covered Days	IPPS Average Cost	IPPS Mortality	Total LTC-PPS Cases	LTC-PPS Average Covered Days	LTC-PPS Average Cost	LTC-PPS Mortality		
262	602	4	6,874	0.00	1	38	67,709	-	762%	885%
263	22,572	10	13,731	0.02	197	37	43,330	0.09	270%	216%
264	3,914	6	7,650	0.00	5	29	27,535	-	383%	260%
265	4,146	6	12,214	0.01	6	31	48,611	0.17	399%	298%
266	2,325	3	6,880	-	1	30	19,371	-	931%	182%
269	11,118	8	12,463	0.02	48	32	39,268	0.06	310%	215%
270	2,612	3	6,144	-	1	19	23,748	-	450%	287%
271	21,879	7	7,251	0.02	370	27	28,189	0.11	304%	289%
272	6,131	6	7,636	0.03	5	26	29,418	-	357%	285%
274	2,281	6	8,498	0.16	5	22	25,555	0.40	269%	201%
276	1,639	4	5,300	0.01	2	18	21,674	-	293%	309%
277	120,095	5	6,226	0.01	191	21	22,225	0.07	292%	257%
278	34,217	4	3,957	0.00	26	17	13,278	-	331%	236%
280	19,421	4	5,498	0.01	6	25	21,178	-	540%	285%
281	6,606	3	3,751	0.00	1	26	17,400	-	873%	364%
283	6,854	4	5,664	0.01	9	19	25,189	-	317%	345%
284	1,892	3	3,375	0.00	1	10	11,606	-	253%	244%
285	8,071	9	15,108	0.01	18	32	44,374	0.06	236%	194%
287	5,465	9	12,889	0.02	29	32	43,734	0.14	261%	239%
292	7,615	10	18,819	0.04	12	29	34,469	-	199%	83%
294	98,395	4	5,605	0.01	99	25	26,543	0.04	503%	374%
295	4,382	3	5,547	0.00	1	15	15,318	-	338%	176%
296	249,150	5	5,935	0.03	95	21	24,492	0.14	367%	313%
297	43,004	3	3,615	0.01	5	21	19,161	-	590%	430%
300	21,883	6	8,013	0.02	2	22	25,350	1.00	276%	216%
304	14,194	8	18,061	0.02	2	22	28,526	0.50	175%	58%
306	5,830	5	9,489	0.01	1	18	29,374	-	229%	210%
315	34,877	6	15,232	0.02	27	36	50,284	0.07	458%	230%
316	205,556	6	9,061	0.07	186	22	26,350	0.14	261%	191%
317	2,701	3	5,742	0.02	7	32	27,376	-	846%	377%
318	6,019	6	8,918	0.09	5	15	17,497	0.40	152%	96%
320	226,630	5	6,115	0.02	113	20	21,209	0.05	314%	247%
321	32,390	3	4,136	0.00	5	17	15,239	-	381%	268%
323	20,515	3	6,076	0.00	1	26	27,553	-	761%	353%
331	57,231	5	8,092	0.02	43	23	26,009	0.09	350%	221%
336	28,220	3	6,319	0.00	1	27	18,876	-	754%	199%
339	1,237	5	9,334	0.00	1	8	27,128	-	57%	191%
341	3,151	3	9,609	0.00	1	27	46,592	-	798%	385%
345	1,400	5	9,500	0.01	1	11	6,041	-	110%	-36%
350	7,319	4	5,553	0.01	5	24	26,545	-	446%	378%
352	1,188	4	5,564	0.01	2	40	46,017	-	868%	727%
366	4,751	6	9,132	0.11	10	24	31,274	0.30	287%	242%
367	461	3	4,437	0.03	1	5	3,010	1.00	63%	-32%
368	4,189	6	8,220	0.02	2	23	23,755	-	266%	189%
369	3,815	3	4,612	0.00	1	18	19,128	-	470%	315%
395	116,761	4	6,063	0.01	9	18	20,966	0.11	360%	246%
397	16,590	5	11,367	0.04	3	23	18,342	-	354%	61%
398	19,037	6	9,274	0.03	7	14	20,193	-	159%	118%
399	1,673	3	4,992	0.01	1	7	2,983	-	115%	-40%
401	6,556	11	21,625	0.08	4	26	41,682	-	143%	93%
403	32,187	8	13,678	0.12	27	22	26,482	0.15	181%	94%
408	2,052	8	16,614	0.05	1	43	86,491	-	448%	421%
409	1,768	6	9,916	0.04	28	21	27,014	0.07	263%	172%
410	30,794	4	8,394	0.01	5	31	65,917	0.20	738%	685%
413	5,841	7	9,849	0.15	1	39	60,026	1.00	493%	509%
418	30,198	6	8,113	0.01	160	24	29,372	0.01	313%	262%
421	13,325	4	5,759	0.01	7	21	26,227	-	450%	355%
423	9,161	8	13,784	0.07	26	22	35,991	0.19	187%	161%

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Appendix 5 cont'd. Comparison of Resources by DRG for IPPS and LPPS for 25 percent Policy Cases

	IPPS				LTC-PPS					
DRG	Total IPPS Cases	IPPS Average Covered Days	IPPS Average Cost	IPPS Mortality	Total LTC-PPS Cases	LTC-PPS Average Covered Days	LTC-PPS Average Cost	LTC-PPS Mortality	Difference IPPS to LTC-PPS Covered Days	Difference IPPS to LTC-PPS Cost
429	56,674	9	7,018	0.01	6	25	19,319	-	177%	175%
430	347,528	10	6,957	0.00	2	20	11,668	-	98%	68%
439	1,773	8	15,354	0.01	6	35	40,828	0.17	344%	166%
440	5,223	8	13,571	0.01	13	35	36,452	0.15	356%	169%
442	18,634	8	18,983	0.04	7	25	47,257	-	205%	149%
444	6,057	4	5,540	0.01	2	22	15,705	-	445%	183%
445	2,293	3	3,885	0.00	1	26	21,408	-	827%	451%
449	41,494	4	6,495	0.02	1	15	18,856	-	318%	190%
452	28,902	5	7,987	0.02	95	22	27,846	0.07	370%	249%
453	5,415	3	3,985	0.00	2	12	12,449	-	352%	212%
461	5,959	13	17,265	0.01	45	35	40,615	0.02	170%	135%
462	287,367	12	10,465	0.00	240	23	21,706	0.04	95%	107%
463	33,944	4	5,293	0.01	17	23	27,303	0.12	470%	416%
464	7,801	3	3,826	0.00	3	18	11,162	-	529%	192%
465	269	6	6,164	0.00	103	21	22,235	0.07	240%	261%
466	2,252	8	7,239	0.01	359	21	21,318	0.04	166%	194%
467	1,195	3	3,931	0.05	2	43	111,689	-	1313%	2741%
468	52,150	12	27,695	0.08	103	36	59,445	0.10	200%	115%
473	8,934	12	25,581	0.24	3	23	30,313	-	92%	18%
476	2,856	10	14,887	0.02	1	14	13,085	-	43%	-12%
477	28,286	8	14,734	0.03	31	30	45,251	0.13	268%	207%
487	4,961	6	14,911	0.16	2	35	39,039	-	463%	162%
488	828	16	39,074	0.12	1	26	33,688	-	59%	-14%
489	13894	8	14,245	0.08	18	25	38,104	0.06	217%	167%
493	61078	6	13,278	0.01	3	30	50,977	-	409%	284%
499	35334	4	10,436	0.00	1	62	78,596	-	1437%	653%
501	3185	9	17,922	0.02	6	39	47,070	0	312%	163%
506	990	15	33,194	0.06	1	31	55,102	1	109%	66%
508	675	7	10,873	0.04	2	24	27,144	0	225%	150%
509	159	5	6,677	0.03	1	21	10,748	-	341%	61%
510	1,834	6	10,427	0.03	3	19	22,107	-	211%	112%
515	58,322	4	38,847	0.01	2	35	61,630	-	838%	59%
521	39,139	6	5,446	0.00	2	30	28,274	0.50	436%	419%
524	109,562	3	5,246	0.00	3	22	18,280	-	623%	248%
531	4,924	9	23,787	0.03	1	19	23,549	-	123%	-1%
537	8,995	6	13,707	0.01	5	35	43,725	-	456%	219%
541	25,192	39	133,617	0.27	12	45	101,755	0.58	15%	-24%
542	23,427	29	77,782	0.23	51	44	93,995	0.24	54%	21%
545	43,671	5	18,835	0.01	1	39	73,645	-	702%	291%
551	53,935	6	22,174	0.02	1	40	59,829	-	568%	170%
553	39,338	9	21,587	0.06	5	23	34,246	-	165%	59%
554	77,404	5	15,390	0.01	1	31	40,491	-	471%	163%
561	6,506	10	19,760	0.07	32	26	27,964	0.09	170%	42%
562	63,619	4	7,316	0.02	8	25	26,428	-	461%	261%
563	27,421	3	4,824	0.00	2	29	18,982	-	852%	293%
565*	120,632	10	24,911	0.33	491	31	59,019	0.28	205%	137%
567	27,304	13	30,053	0.10	2	32	42,175	0.50	154%	40%
569	133,594	12	24,881	0.07	2	40	50,274	-	239%	102%
576	289,556	7	12,317	0.20	449	21	26,196	0.15	196%	113%
578	56,031	13	28,068	0.12	86	33	43,085	0.06	149%	54%

*Note that DRG 565 also includes DRG 566 cases when crosswalking V.21 (FY2005 data) to V.23 cannot determine which proportion of DRG 475 should be DRG 566.

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March 23, 2007

The Honorable Leslie V. Norwalk, Acting Director
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1529-P
Mail Stop C4026-5
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: 2007 Proposed Rule for GME/IME Response

Dear Administrator Norwalk,

In response to the 2007 rule for GME/IME as proposed by CMS, the University of New England College of Osteopathic Medicine along with its affiliate hospital Southern Maine Medical Center both in Biddeford, Maine would like to take this opportunity to comment on several aspects of the rule.

First, allow me to thank CMS for attempting to better communicate with us and other GME programs in defining the financial obligations our programs face. This improved communication will hopefully allow us a better opportunity for financial planning with fewer instances of the "disallowances" we have incurred in the recent past following CMS audits of our programs due to ambiguous interpretations by our fiscal intermediaries regarding "all or substantially all" of the teaching costs for physicians in group practices.

I. Regarding the proposed implementation time frame:

We would encourage CMS to make this new rule effective as soon as possible without regard to the hospital cost reporting period.

CMS has proposed a start date of July 1, 2007 and is considering making it effective with cost reporting periods beginning after that date. We would encourage CMS to make the effective date the beginning of the upcoming GME academic period (on July 1, 2007) without regard to the cost reporting period. Although CMS cites concerns with the logistics of implementing the new regulations in the middle of a hospital's cost reporting period, the implementation burden is much less than the financial burden will be on our institutions if CMS delays our start date to May 2008 (the next cost reporting period following July 1, 2007).

Due to prior CMS audit financial disallowances and paybacks, our programs are currently in jeopardy of large cutbacks and being unable to accommodate the residents we currently employ, possibly severely interrupting their graduate medical education training. By delaying this improved

communication and opportunity for detailed financial planning, CMS could further place our programs and our residents at risk.

II. Written Agreements:

Our programs have been meeting this current regulation for several years by providing the non-hospital teaching physicians with a written agreement for resident time spent in the non-hospital site. The amount of the hospital payment to the non-hospital teaching physician is indicated, signatures are obtained prior to the start of the rotation and agreements are provided to CMS for audit purposes. With the implementation of this new rule, we would further indicate "the amount of cost" for the rotating resident according to the new CMS guidelines.

We do believe that the rule regarding "actual payment within three months in which the rotation occurred" should be changed, however. CMS currently insists that the three-month (90 day) time frame for payment be based on a calendar month without regard to programs such as ours that conduct rotations on a 4-week basis (13 rotations per year) rather than a calendar month basis.

This rule places a tighter time frame on payments to the non-hospital teaching physician for these programs by decreasing our grace period by as much as 30 days. If a rotation block begins the last day of a calendar month, we are obligated to pay the non-hospital physician within 90 days of the FIRST day of that rotation instead of the last day of that rotation.

We believe the written agreement is reasonable but the 90-day time frame for payment to the non-hospital physician should be relative to the last day of the block rotation.

III. Determination of 90 Percent Threshold

CMS lists 4 variables for determining the 90 percent threshold:

1) Teaching physician compensation:
   CMS is requesting comments on four areas of this part of the proposal:

   a) Concerning the mean or the median compensation amount, we would suggest CMS use the median amounts for purposes of determining the teaching physician's cost.

   b) Regarding AMGA's data exclusively or blended with other data, we would suggest either one or the other or a blend would be sufficient, however CMS should be obligated to disclose the manner in which it obtains its data.

Regarding the issue of specialties not tracked by the databases, the CMS proposal to use the immediate next less-specialized form of that specialty (i.e.: if Pediatric Neurosurgery specialty is not tracked using data for Neurosurgery would be reasonable).

However, there are sub-specialties in which there are no national or regional data and no "immediate next less-specialized form of that specialty", such as "Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine" (NMM/OMM) specialty. We would suggest that CMS seek guidance from the AOA (or likewise the AMA for allopathic sub-specialties that fit this category) for sub-specialties that do not easily fit into the proposed guidelines. Additionally, CMS should encourage the national data survey groups to begin tracking such sub-specialties in the future.

c) Regarding whether the data should be adjusted for geographic variation in salaries. We absolutely believe that physician compensation should take into account geographic variation. We are in a small rural state and like many other smaller Osteopathic graduate medical education programs, could be placed at a higher financial burden compared to programs in larger medical centers with significantly higher physician compensation, higher cost of living, etc.

d) Concerning the best means of making the data available efficiently, we agree with CMS that the data should be published and maintained on the CMS website. The means by which CMS determines the data should also be clearly delineated. Hospitals using the data supplied by CMS at the beginning of its cost reporting period would be reasonable for financial planning.

2) The number of hours per week that the teaching physician spends in the direct GME (non-billable) activities in the non-hospital site:

CMS's proposed proxy of 3 hours is based on unsubstantiated and informal surveys supplies by the AFMAA, AOA and AAMC. The implications of this 3-hour proxy are extremely significant in determining hospital financial costs. In this matter, we believe CMS should conduct a more thorough, well-designed,

formal survey (possibly through teaching hospitals in various settings).

Our Graduate Medical Education Department has been conducting ongoing surveys of our non-teaching hospital physicians (group, solo, and academic) from May of 2005 through February of 2007. According to our survey (85 responses in that time period), a more accurate proxy would be 2 hours per week for non-patient care teaching time and administrative time.

The figure CMS chooses to use for the proxy time is of great importance to small GME programs such as ours as even a 30 minute change in the proxy can mean thousands of dollars of added expense to our programs. Like many small, rural GME programs, we heavily utilize non-hospital physicians for training or residents and although we have been highly successful in recruiting local solo practitioners in many specialties, in order to maintain the high quality of educational experience for our trainees, we must utilize a number of group practices.

We would highly encourage CMS to adjust this 3-hour proxy downward and/or conduct a more formal survey.

Additionally, if CMS allows programs to use actual survey data from their teaching physicians for direct GME (non-billable) activities in the non-hospital site, we would suggest that CMS develop an approved survey for use by hospitals. It is our concern that although we currently utilize such a survey to determine this time, our surveys will be disallowed by CMS as "unsubstantiated" information and therefore become useless to us obligating us to utilize CMS's proxy in the end.

3) The number of hours that a non-hospital site is open each week:

This is an easily obtainable figure and is useful to determine the amount of teaching time as a percent of the total time a supervising physician spends on the job.

Two caveats apply to this figure, however. In most primary care residencies, such as ours, the resident is obligated by the basic standards for that specialty as published by the AOA (and likewise the AMA) to be in their own continuity clinics for up to 20+ hours per week. One can see that although the teaching physician may be available for patient care and training, our residents are typically available for training at the non-hospital

site for less than 50% of the time the office is open for clinic hours, which serves to significantly decrease the amount of teaching obligation by the physician.

Secondly, as we were calculating the time a group's practice is open (for example: 9am-4:30pm), it became clear that many physician offices actually close for a lunch hour and this office closure was not taken into account. Although it seems small, if a physician's office closes daily for lunch that adds up to 5 hours per week and could alter the final outcome of determining the non-hospital teaching physician obligation and therefore cost.

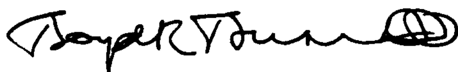
4) Resident compensation:

This is an easily obtainable and published figure.

In summary:

1) We commend CMS's efforts at improving communication with GME programs.
2) We encourage an implementation date as soon as possible, July 1, 2007, without regard to hospital cost reporting periods.
3) We encourage a more appropriate proxy (lowered to 2 hours) to be used for determining time the teaching physician spends in direct GME (non-billable) activities in the non-hospital site.
4) We encourage well-publicized and easily obtainable physician compensation data.
5) If CMS proposes to allow hospitals to survey their teaching physicians to determine the direct GME activities, CMS should create an approved survey for hospital use.

Respectfully submitted,



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Attachments: Group Rotation Examples utilizing CMS proposed rule, UNECOM

cc: Doris Newman, DO, Director Graduate Medical Education, UNECOM
Ken Johnson, DO, FAAO, Associate Dean for Clinical Affairs, UNECOM
Jim Geaumont, Accounting Dept., Southern Maine Medical Center

Margaret Hardy, JD, Director, Hospital and Medical Educator Affairs, AOA
Senator Olympia Snowe
Senator Susan Collins
Representative Tom Allen
Representative Michael Michaud

UNECOM/SMMC GME GROUP ROTATION SAMPLES UTILIZING CMS' NEW RULES

Four sample group rotations calculated utilizing the CMS suggested 3 hour proxy compared to UNECOM/SMMC surveys indicating 2 hour proxy as more accurate:

1) Teaching time proxy discussion:

    a. 3 hour proxy obtained from page 4826 of the Federal Register/Vol. 72, No. 21/Thursday, February 1, 2007/Proposed rule: "The surveys showed means ranging from 1.1 to 4.0 hours per week and medians of 1.5 to 4.0 hours per week for the time spent on residency training when patients were not present. The surveys also showed means ranging from 1.6 to 4.7 hours per week for time spent on administrative activities related to residency training at the non-hospital site. Given the range of survey results, we (CMS) believe that 3 hours per week serves as a reasonable number to use as a shortcut or a proxy"
    b. 2 hour proxy obtained via an on-going survey conducted by University of New England's Graduate Medical Education Department from May 2005 through February 2007. These surveys were sent to all precepting physicians (solo and group). Eighty-seven surveys were returned with 49 surveys indicating an average 1.1 hours of non-patient teaching time per week and 0.63 hours of administrative time per week (typically the time it takes to complete a resident evaluation form) 1.1 + 0.63 = 1.73 hours per week of non-patient related teaching/admin time. The other 38 surveys did not have these blanks filled in.

       Additionally, there were 3 physician surveys that indicated 8 hours of non-patient teaching time, however these 3 physicians indicated classroom teaching time (outside of resident rotation time) as being included in these numbers. Adding these 3 inflated times gives us 52 surveys completed and increases the average non-patient related teaching time to 1.5 hours plus the administrative time of 0.63 hours = 2.13 non-patient teaching/admin hours per week.

       If we average 1.73 and 2.13 we get 1.93 which we can round up to a more realistic 2 hours per week non-patient related teaching time proxy.

2) UNECOM Resident compensation per year in training (2006-2007):

    i. PGY1 = $39,923 + 24% benefits of $9,581 = $49,504
    ii. PGY2 = $42,024 + 24% benefits of $10,085 = $52,109
    iii. PGY3 = $44,125 + 24% benefits of $10,590 = $54,715
    iv. PGY4 = $46,226 + 24% benefits of $11,094 = $57,320

EXAMPLE #1: (3 hour proxy suggested by CMS)

Orthopedic surgery physician compensation utilizing CMS 3 hour proxy:

a) Two of the 3 physicians at this site participate in GME and the average salary for 2 teaching physicians per the AGMA 2006 web-site for orthopedic surgeons:

$409,518

b) The number of hours that this non-hospital site is open each week: Monday-Thursday 8am-4:30pm and Friday 8-3pm =

41 hours per week

c) Total annual salary for two teaching physicians at this non-hospital site:

hospital multiplies the average salary times the two physicians:
$409,518 x 2 = $819,036

d) Assuming 3hr teaching time and 41hrs per week of open clinic (3/41) = 7.3%

e) Annual teaching physician cost for teaching activities at this non-hospital site:

$819,036 x 7.3% = $59,790

f) This site takes 3 residents per year for 4 weeks each (3 rotations per year for 4 weeks per rotation); therefore total teaching physician cost for teaching activities:

$59,790/52 weeks= $1,150/week x 12 weeks per year = $13,800

g) Actual resident compensation for 3 residents (2 in PGY3 and 1 in PGY2 years) at this site:

$54,715 x 2 + $52,109 = $161,539 / 52 weeks = $3,106/week
$3,106 x 12 weeks per year = $37,272

h) Total cost for the training program at this non-hospital site: Annual physician compensation = $13,800 plus actual resident's compensation $37,272

$13,800 + $37,272 = $51,072

i) To meet the proposed definition of "all or substantially all", the hospital must incur 90% of $51,072 =

$45,965

j) Resident compensation is $37,272 so the hospital does not reach 90%. The threshold amount less the amount already paid to the resident equals the amount the hospital must pay this non-hospital teaching site per year utilizing the 3 hour proxy.

$45,965 - $37,272 = $8,693

EXAMPLE #2: (2 hour proxy suggested by UNECOM/SMMC)

The same orthopedic physician group in example #1 utilizing UNECOM survey for physician teaching time or 2 hours proxy per week:

a) Average salary for 2 teaching physicians at this site $409,518

c) Total annual salary for two teaching physicians at this non-hospital site: hospital multiplies the average salary times the two physicians

$409,518 x 2 = $819,036

c) Assuming 2hr teaching time and 41hrs per week of open clinic (2/41) = 4.8%

d) Annual teaching physician cost for teaching activities at this non-hospital site:

$819,036 x 4.8% = $39,313

e) This site takes 3 residents per year for 4 weeks each (3 rotations per year for 4 weeks per rotation); therefore total teaching physician cost for teaching activities:

$39,313/52 weeks= $756/week x 12 weeks per year = $9,072

f) Actual resident compensation for 3 residents (2 in PGY3 and 1 in PGY2 years) at this site for a total of 4 weeks each or 12 weeks total:

$54,715 x 2 + $52,109 = $161,539 / 52 weeks = $3,106/wk
$3,106 x 12 weeks per year = $37,272

g) Total cost for the training program at this non-hospital site: annual physician compensation = $9,072 plus actual resident's compensation $37,272:

$9,072 + $37,272 = $46,344

k) To meet the proposed definition of "all or substantially all", the hospital must incur 90% of $46,344 =

$41,710

l) Resident compensation is $37,272 so the hospital does not reach 90%. The threshold amount less the amount already paid to the resident equals the amount the hospital must pay this non-hospital teaching site per year utilizing the 2 hour proxy suggested by UNECOM.

$41,710 - $37,272 = $4,438

EXAMPLE #3: (3 hour proxy suggested by CMS)

Pediatric physician compensation utilizing CMS 3 hour proxy:

a) Two of the 3 physicians at this site participate in GME and the average salary for 2 teaching physicians per the AGMA 2006 web-site for general pediatrics and adolescent medicine:

$182,186

b) The number of hours that this non-hospital site is open each week: Monday-Friday 9am-5pm = 35

35 hours per week

c) Total annual salary for two teaching physicians at this non-hospital site: hospital multiplies the average salary times the two physicians:

$182,186 x 2 = $364,372 per year

d) Assuming 3hr teaching time and 35 hrs per week of open clinic (3/35) = 8.6%

e) Annual teaching physician cost for teaching activities at this non-hospital site:

$364,372 x 8.6% = $31,335 annually

f) This site takes 6 residents per year for 4 weeks each (6 rotations per year for 4 weeks per rotation); therefore total teaching physician cost for teaching activities:

$31,335/52 weeks= $603/week x 24 weeks per year = $14,427

g) Actual resident compensation for 6 residents (3 in PGY3 and 3 in PGY2 years) at this site for 4 weeks each (or 24 weeks total):

$54,715 x 3 + $52,109 x 3 = $320,472/ 52 weeks = $6,163/wk
$6,163 x 24 weeks per year = $147,912

h) Total cost for the training program at this non-hospital site: 24 weeks per year for the annual physician compensation = $14,427 plus actual resident's compensation $147,912 for that time period:

$14,427 + $147,912 = $162,339

i) To meet the proposed definition of "all or substantially all" of the total teaching physician cost the hospital must incur: 90% of $162,339 =

$146,105

j) Resident compensation is $147,912 so the hospital does exceed 90% of the threshold of $146,105 by $1,807 utilizing the 3 hour proxy proposed by CMS and need not compensate this group practice further

EXAMPLE #4: General Pediatric and Adolescent teaching site as above using the UNE/SMMC suggested 2 hour proxy

d) Assuming 2 hours teaching time and 35 hrs per week of open clinic (2/35) = 5.7%

e) Annual teaching physician cost for teaching activities at this non-hospital site:

$364,372 x 5.7% = $20,769 annually

f) This site takes 6 PGY1 residents for 4 weeks each (24 weeks of training per year); therefore total teaching physician cost for teaching activities:

$20,769/52 weeks=$399/week x 24 weeks per year = $9,576

g) Actual resident compensation for 6 residents as noted in example #3:

$147,912

i) Total cost for the training program at this non-hospital site: physician compensation plus resident compensation:

$9,576 + $147,912 = $157,488

j) To meet the proposed definition of "all or substantially all" of the total teaching physician cost the hospital must incur 90% of $157,488 or $141,739 for this teaching site.

k) Resident compensation is $147,912 so the hospital does exceed the 90% of the threshold of $141,739 by $6,173 utilizing the 2 hour proxy proposed by UNE and need not compensate this group practice further.

EXAMPLE #5: Obstetrics and Gynecology physician compensation utilizing CMS 3 hour proxy:

a) One of the 8 physicians at this site participate in GME and the salary for one teaching physicians per the AGMA 2006 web-site for obstetrics and gynecology:

$271,273

b) The number of hours that this non-hospital site is open each week: Monday-Friday 9-3:30 =

27.5 hours per week

c) Total annual salary for one teaching physicians at this non-hospital site:

$271,273

d) Assuming 3hr teaching time and 27.5 hrs per week of open clinic (3/27.5) = 11%

e) Annual teaching physician cost for teaching activities at this non-hospital site:

$271,273 x 11% = $29,840

f) This site takes 6 residents per year for 4 weeks each (6 rotations per year for 4 weeks per rotation or 24 weeks per year); therefore total teaching physician cost for teaching activities:

$29,840/52 weeks= $574/week x 24 weeks per year = $13,776

g) Actual resident's compensation for 6 first year residents (6 in PGY1) at this site:

$49,504 x 6 = $297,024 / 52 weeks = $5,712
$5,712 x 24 weeks per year = $137,088

h) Total cost for the training program at this non-hospital site: 24 weeks per year the annual physician compensation = $13,776 plus actual resident's compensation $137,088

$13,776 + $137,088 = $150,864

i) To meet the proposed definition of "all or substantially all", the hospital must incur 90% of $150,864 =

$135,776

j)Resident compensation is $137,088 so the hospital does reach over 90% of the threshold amount of $135,776 by $1,312 using the 3 hour proxy.

EXAMPLE #6: OB/Gyn teaching site as above utilizing the 2 hour proxy:

d) Assuming 2hr teaching time and 27.5 hrs per week of open clinic (2/27.5) = 7.3%

e) Annual teaching physician cost for teaching activities at this non-hospital site:

$271,273 x 7.3% = $19,531

f) This site takes 6 residents per year for 4 weeks each (6 rotations per year for 4 weeks per rotation or 24 weeks per year); therefore total teaching physician cost for teaching activities:

$19,531/52 weeks= $376/week x 24 weeks per year = $9,024

g) Actual resident's compensation for 6 first year residents (6 in PGY1) at this site:

$49,504 x 6 = $297,024 / 52 weeks = $5,712
$5,712 x 24 weeks per year = $137,088

h) Total cost for the training program at this non-hospital site: 24 weeks per year the annual physician compensation = $9,024 plus actual resident's compensation $137,088

$9,024 + $137,088 = $146,112

i) To meet the proposed definition of "all or substantially all", the hospital must incur 90% of $146,112 =

$131,501

j)Resident compensation is $137,088 so the hospital does reach over 90% of the threshold amount of $135,776 by $5,587 using the 2 hour proxy.

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March 23, 2007

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

Re: Comments on Proposed Medicare Regulations, File CMS-1529-P

Dear Ms. Norwalk:

I am writing on behalf of Good Shepherd, a post-acute healthcare system based in Allentown, Pennsylvania, to submit comments on proposed Medicare rules regarding LTCHs published on February 1, 2007. Our LTCH, Good Shepherd Specialty Hospital (GSSH), is one of two LTCHs in the Allentown-Bethlehem-Easton metropolitan area. The hospital has 32 beds and has been in operation since January 2000. In addition, we are developing an LTCH in partnership with the University of Pennsylvania Health System to be located in Philadelphia, Pennsylvania.

Good Shepherd is proud of the service that GSSH provides. We see patients from all the hospitals in our region and beyond. Physicians recognize us as an outstanding place to send patients with complex medical problems that require special care, such as ventilator weaning and healing of severe wounds. Our ability to treat such patients is far superior to that of short-term acute care hospitals in our region. Consequently, we are able to achieve desired patient outcomes, such as getting patients off ventilators or healed wounds, faster or more often.

Our region is one of the faster growing areas within the Commonwealth of Pennsylvania. As a result, most of the short-term acute care hospitals are operating at or near capacity. During peak demand periods, they are forced to divert patients from our area trauma centers, due to lack of adequate bed capacity. LTCHs in our region play an important role in maximizing throughput in our area, reducing the number of new short-term acute care beds needed.

At Good Shepherd, we feel it would be a serious mistake to adopt the above referenced regulations. We believe adopting them would hurt patient access and choice, reduce competition and ultimately result in worse Medicare patient outcomes and higher cost to the Medicare program. Our reasons are given below. In addition, the proposed regulations threaten the financial viability of Good Shepherd Specialty Hospital. We estimate this could negatively affect us by as much as $2.1 million. This would primarily be due to the proposed expansion of the 25 percent rule that applies to LTCHs.

THE GOOD SHEPHERD HOME and its affiliates are tax exempt organizations as provided by IRS regulations. Pennsylvania law requires us to inform you that a copy of the official registration and financial information may be obtained from the Pennsylvania Department of State by dialing toll free, within Pennsylvania, 1.800.732.0999. Registration does not imply endorsement.

OTHER PROPOSED POLICY CHANGES FOR THE 2008 LTCH PPS RATE YEAR -- EXPANDED 25 PERCENT RULE

1. There Is No Valid Foundation for Having A 25 Percent Rule

CMS adopted the current 25 percent rule for LTCHs, based on the presumption that a significant number of short-term acute care hospital discharges to LTCHs are premature discharges; i.e., Medicare beneficiaries receiving care provided at LTCHs should have received that care at their original short-term hospital instead. There is no clinical or financial evidence to support CMS' conclusion that LTCH patients are discharged prematurely. Research Triangle Institute. CMS' contractor investigating these issues said it was not possible to conclude that LTCHs are substituting for services that already covered by the DRG payments to IPPS hospitals. Without such evidence the 25 percent rule should not be expanded. Rather it should be totally withdrawn.

2. In Many Cases The 25 Percent Rule Will Reduce Patient Choice, Not Save Any Money and Harm Medicare Patient Health

In regions like ours where there are a few very large short-term acute care hospitals, it is often difficult, if not impossible, to accept appropriate LTCH patients without exceeding the 25 percent threshold. Many patients will be forced to seek care at a different LTCH that is less convenient or perhaps provides lower quality. In such cases, Medicare is not saving any money. It is still paying for LTCH services. Instead, it is the Medicare beneficiaries that suffer. At a time when Medicare officials are touting transparency and patient choice, the 25 percent rule produces the opposite effect. Patients will be turned away from the best LTCHs.

In other cases, where there is no convenient access to another LTCH, the patient might be forced to receive sub-standard care in a short-term acute care hospital setting that does not have the special programs that the LTCHs offer. This can result in poorer health outcomes, much longer hospital stays in the long run and, potentially even higher costs where medical complications arise or get worse.

3. The 25 Percent Rule Ignores Physician Referral Patterns & Reduces Continuity of Care

A fact of life that all LTCHs face is that many physicians want to follow their patients, if they need additional inpatient care. That fosters referrals from short-term acute hospitals to nearby LTCHs, where the original attending physicians can continue to follow their patients during their LTCH stay. This relationship naturally produces a disproportionate number of admissions to an LTCH from neighboring or host hospitals. That phenomenon should not be seen as a reflection of inappropriate LTCH admissions.

4. Adopt InterQual Admission Criteria In Lieu of Using the 25 Percent Rule

If CMS truly wants to prevent inappropriate admissions to an LTCH, it should address the issue directly, rather than adopt arbitrary rules that have no valid basis. Good Shepherd supports the use of InterQual admission criteria for LTCHs as an alternative to use of the 25 percent rule for Medicare beneficiaries. Many private insurance companies use those criteria now.

5. <u>If CMS Refuses to Eliminate the 25 Percent Rule, Then It Should Adopt Different Criteria for Excluding Cases from the 25 Percent Calculation</u>

   The proposed regulations provide that patients who are Medicare IPPS cost outliers will not be counted in the calculation of whether less than 25 percent of all Medicare patients came from a particular short-term acute hospital. If such exceptions are to be allowed, CMS should use some metric other than cost outlier status to identify such cases. In the real world, it is not possible to determine whether patients are cost outliers, before they are discharged. CMS should provide a different metric, such as short-term hospital length of stay, that LTCHs can measure prior to making an admission decision for each Medicare beneficiary.

6. <u>If CMS Adopts New 25 Percent Regulations, Then It Should Provide A Four Year Transition Period for Their Implementation</u>

   The proposed regulations provide for a one year transition period for application of the 25 percent rule to freestanding hospitals. Because the expanded 25 percent rule will generally have a greater detrimental impact on hospitals within hospitals, any transition period should be applied to all LTCHs, and not just freestanding LTCHs.

   Furthermore, due to the devastating impact of the 25 percent rule on LTCHs, we should be given a reasonable amount of time to make adjustments in operations. Previously, there was a four year transition period provided for the original 25 percent rule. We believe the same period should be provided if the new 25 percent rule is adopted.

OTHER PROPOSED POLICY CHANGES FOR THE 2008 LTCH PPS RATE YEAR --
SSO PAYMENT POLICY CHANGE

1. <u>The Proposed SSO Payment Policy Change is Unfair to LTCHs</u>

The proposed SSO payment policy change is unfair to LTCHs, because they cannot predict in advance who will become SSO cases. There are a myriad of reasons why a patient admitted to an LTCH might become a SSO. LTCH 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. Some SSO cases may achieve medical stability sooner than originally expected. Other cases 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 LTCH become SSO cases due to unexpected death. Some patients and their families, after realizing the gravity of their condition, may simply give up and request that aggressive treatment be stopped after admission. Other patients may sign themselves out against medical advice.

Under the current SSO policy a LTCH will at best receive only its cost for an SSO case. Hence, there is no incentive for a LTCH to admit a patient who is likely to become an SSO. Under the new SSO payment policy being considered, LTCHs could lose a significant sum treating patients that become SSO cases. That is unfair, because for all of the reasons given above, LTCHs cannot be expected to know in advance not to admit patients, because they will become SSO cases later.

3. Calculation of IPPS Equivalent Amounts

   If CMS adopts the proposed change in SSO payment policy anyway, then it should incorporate outlier payments when determining an equivalent IPPS payment amount in the SSO payment methodology.

4. Regulations Cannot Be Adopted Before They Are Formally Submitted to the Public For Comment

   In the proposed regulation change document discussed here, no specific regulatory language revisions were proposed for the payment of Medicare SSO cases. Consequently, under the Administrative Procedures Act, CMS cannot adopt the SSO payment policy changes without publishing proposed language and providing for the required public comment period.

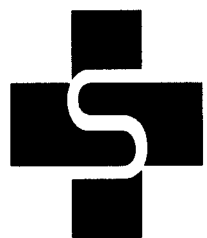
We hope that you take these concerns seriously as you consider public comment on the proposed LTCH regulations. If you or your staff have questions regarding this letter, please feel free to call me at 610 776-3133.

Sincerely,

Sally Gammon, FACHE
President & CEO

cc: Senator Arlen Specter
    Senator Robert Casey
    Congressman Charles Dent

36-1



March 21, 2007

The Honorable Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1529-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: ***Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 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:

As a Board Member for Norman Specialty Hospital, I have serious concerns about the proposed "long term acute care" (LTAC) hospitals regulation the Centers for Medicare and Medicaid Services (CMS) published on January 25th, 2007, that introduces significant changes to the way LTAC hospitals are reimbursed by Medicare. While I understand CMS has concerns about the number of LTAC hospitals, an arbitrary admission quota is not a good answer. The use of clinical admission criteria, as included in legislation introduced in both the U.S. Senate and House of Representatives, is a much more appropriate way to ensure only appropriate patients are treated in LTAC hospitals. CMS' proposal is full of inequity, especially for smaller cities that have only a few general hospitals. Local LTACH care should not be restricted to only a few very large cities.

Comments on the proposed rule are summarized in the following paragraphs:

"OTHER PROPOSED POLICY CHANGES FOR THE 2008 LTCH PPS RATE YEAR"

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Proposed Extension of 25% Patient Quota Rule to Freestanding LTAC hospitals. CMS proposes a payment penalty for freestanding LTAC hospitals for every patient over a 25% threshold that comes from any single acute care hospital referral source from this rule. The proposed regulation would limit the way patients are referred to LTAC hospitals, an LTAC hospital could not have more than 25% of its patients referred from any one general hospital. I would like to comment on some of the harmful impact to my patients and LTAC hospitals the regulation would cause, as well as better options to achieve the same goals:

1. With respect to the proposed rule, the Medicare Payment Advisory Commission (MedPAC) has noted that these referral quotas are a rather crude and unsophisticated approach to dealing with hospital admissions.

2. It has been almost three years since MedPAC called for CMS to create certification criteria to address the growth of the number of LTAC hospitals. Instead of imposing a crude and unfair quota rationing system, CMS should develop certification criteria for America's LTAC hospitals.

3. Late last year, CMS received a report from RTI that it commissioned regarding LTAC hospital certification criteria. The RTI study was generally positive for the LTAC hospital industry, conclusively acknowledging that LTAC hospitals play a legitimate and constructive role in the continuum of American healthcare services. This proposed CMS quota rule pays little heed to the RTI study which CMS commissioned and funded. The proposed quota rule will cause many LTAC hospitals to close, especially in underserved and rural areas which have only one or two general hospitals.

4. In the face of several years of regulatory delays, a number of Members of Congress sponsored legislation to address the criteria issue for LTAC hospitals. In the U.S. Senate, Sen. Kent Conrad and Sen. Orrin Hatch introduced S. 338. In the U.S. House, Rep. Earl Pomeroy (D-ND) and Rep. Phil English (R-PA) sponsored a similar bill, H.R. 562. These bills would establish criteria to define what an LTAC hospital is and which patients should be treated there. They would limit the type of patients who can be treated in an LTAC hospital and reduce Medicare spending on LTAC hospitals by $1-2 billion over five years. These bills present a rational way to limit spending on LTAC hospitals, as opposed to the 25% rule that will create unnecessary and uneven hardships for patients and hospitals.

5. A few more examples of harm the 25% rule proposal would cause include:
    - Loss of local LTACH services in all but large metropolitan areas
    - Fragile patients would have long ambulance rides to access LTACH care
    - Families of patients would have long drives to see loved ones in LTAC Hospitals, for over 25 days average hospitalization
    - Patients would have to drive past LTAC hospitals with empty beds in their community and drive to another city to get LTAC care, because of the quotas
    - The 25% quota does not work in Cities with only 1 or 2 acute care hospitals. There is no place for the first 25% of patients to come from, before the matching 25% from the local hospital can be admitted.
    - Constant CMS changes lead to healthcare industry instability

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- The constant annual changing of regulations and reimbursement hurts small businesses that are trying to build long term companies that provide quality healthcare services to very ill patients. Companies cannot plan for the future when CMS significantly changes the regulations every year.
- Capital commitments have been made by companies to build new hospitals; the 25% rule could cause bankruptcies caused by the inability to service lease payments and guaranties that were required to get the new hospitals built.

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.

The affect of the existing 25% rule and other changes made over the last three years have not been fully documented yet and CMS does not yet have data to confirm that the policy is achieving the stated policy goals and not having adverse effects on patient care. The proposed 25% rule expansion is a draconian quota system that would cause the most harm to patients and LTACHs in rural and underserved areas. This proposal should be dropped, if not for all free-standing LTACHs, at least for areas that have less than 4 equivalent STAC hospitals.

If CMS finalizes this policy in spite of strong congressional and industry opposition, all existing and under-development freestanding LTACHs should be grandfathered from compliance with the new rule.

Please consider and decide the following:

1. Not implement a 25% admission limit, if not for all free-standing LTACHS, at least for rural, underserved, and other areas with less than four equivalent sized general hospitals; or
2. If the 25% rule for free-standing hospitals is implemented, permanently grandfather existing LTACHs and hospitals currently being constructed to become LTACHs.

This would provide sensible governing:

- Companies that have invested in and guaranteed long term hospital leases, based on the rules in existence, would have a chance to survive and meet their obligations.
- Appropriate LTACH patients could receive care in their home town, or closer to home, if an LTAC Hospital is already there.
- Patients could be treated by their own doctor, instead of getting a new doctor in the town they have to travel to.
- Families could visit their loved one daily without an extra burden of travel, lodging, meals and other expense and burden.

2. ***CMS is interfering with patient choice and the practice of medicine.*** The proposed rule greatly restricts patient choice and interferes with the practice of medicine by arbitrarily paying LTACHs at the LTACH payment rate for no more than 25% of its patients referred from any one hospital. This policy also violates the agency's own stated goal to place Medicare patients in the most appropriate post-acute care setting. CMS should implement an LTACH PPS that recognizes the medically complex care LTACHs provide and the will of Congress to fairly pay for LTACH services. The Congress, the

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LTACH industry, MedPAC, and RTI International (which recently provided a report to CMS on LTACHs) all agree that LTACHs serve an important role in caring for medically complex patients who need long-term hospital stays. The combined effect of this proposed rule makes clear that CMS does not agree with this most basic premise. These proposed policies will continue to erode the LTACH PPS by reimbursing LTACHs for fewer and fewer medically complex patients at the LTACH PPS rates.

3. CMS must implement an LTACH PPS that fairly reimburses LTACHs for the costs they incur in caring for Medicare beneficiaries, in keeping with the statutory mandate of Congress. The proposed changes to the regulations will bring LTACH reimbursement below their cost of care.

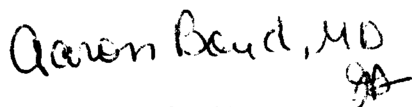
Conclusion

The 25% admission from any one hospital policy will have a disparate impact on LTACHs in areas without at least four equivalent referral hospitals – primarily underserved, rural and other nonurban markets – that is not appropriately accounted for with the limited number of exceptions to the 25% rule. CMS should not extend the current 25% rule, or any similar policy, to freestanding LTACHs or grandfathered LTACHs. However, if CMS finalizes this policy, it should:

(1) Grandfather all existing and under-development freestanding LTAC hospitals from the rule altogether, and
(2) Set the applicable percentage for all new freestanding LTACHs at 50% in light of the lesser policy concerns CMS has with these hospitals as compared to co-located LTACHs, and
(3) Exclude rural areas and other cities with less than 4 equivalent hospitals from the 25% rule.

Thank you for your attention to the important considerations related to LTAC hospitals raised in this letter.

Sincerely



Aaron Boyd, MD
Board of Trustees
Norman Specialty Hospital

cc: Senator James M. Inhofe
Senator Tom Coburn
U.S. Representative Tom Cole

1210 West Robinson Street
Norman, Oklahoma 73069
Ph: 405-321-8824

Norman
Specialty
Hospital

March 20, 2007

The Honorable Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1529-P
P.O. Box 1850
Mail Stop C4-26-05
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:

I'm the administrator of Norman Specialty Hospital in Norman, Oklahoma and have serious concerns about the proposed "long term acute care" (LTAC) hospitals regulation the Centers for Medicare and Medicaid Services (CMS) published on January 25th, 2007, that introduces significant changes to the way LTAC hospitals are reimbursed by Medicare. While I understand CMS has concerns about the number of LTAC hospitals, an arbitrary admission quota is not a good answer. The use of clinical admission criteria, as included in legislation introduced in both the U.S. Senate and House of Representatives, is a much more appropriate way to ensure only appropriate patients are treated in LTAC hospitals. CMS' proposal is full of inequity, especially for smaller cities that have only a few general hospitals. Local LTACH care should not be restricted to only a few very large cities. Plus, even though a smaller city is located next to a larger city, is no reason to penalize the patients and their families by requiring them to drive past their local LTAC to travel into the city for the same service.

Comments on the proposed rule are summarized in the following paragraphs:

A. "OTHER PROPOSED POLICY CHANGES FOR THE 2008 LTCH PPS RATE YEAR"
Proposed Extension of 25% Patient Quota Rule to Freestanding LTAC hospitals. CMS proposes a payment penalty for freestanding LTAC hospitals for every patient over a 25% threshold that comes from any single acute care hospital referral source. In addition, CMS proposes to revoke "grandfather" status from certain "Hospital within Hospital" LTAC hospitals that have been exempt

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from this rule. The proposed regulation would limit the way patients are referred to LTAC hospitals, an LTAC hospital could not have more than 25% of its patients referred from any one general hospital. I would like to comment on some of the harmful impact to patients and LTAC hospitals the regulation would cause, as well as better options to achieve the same goals:

1. The Medicare Payment Advisory Commission (MedPAC) has noted that referral quotas are a rather crude and unsophisticated approach to dealing with hospital admissions. No other Medicare-reimbursed facility has to deal with such non-clinical policies. These admission quota limits ignore the clinical and quality of care considerations that should be the primary determinant of access to LTAC hospital care.

2. It has been almost three years since MedPAC called for CMS to create certification criteria to address the growth of the number of LTAC hospitals. Instead of imposing a crude and unfair quota rationing system, CMS should develop certification criteria for America's LTAC hospitals.

3. Late last year, CMS received a report from RTI that it commissioned regarding LTAC hospital certification criteria. The RTI study was generally positive for the LTAC hospital industry, conclusively acknowledging that LTAC hospitals play a legitimate and constructive role in the continuum of American healthcare services. This proposed CMS quota rule pays little heed to the RTI study which CMS commissioned and funded. The proposed quota rule will cause many LTAC hospitals to close, especially in underserved and rural areas which have only one or two general hospitals.

4. In the face of several years of regulatory delays, a number of Members of Congress sponsored legislation to address the criteria issue for LTAC hospitals. In the U.S. Senate, Sen. Kent Conrad and Sen. Orrin Hatch introduced S. 338. In the U.S. House, Rep. Earl Pomeroy (D-ND) and Rep. Phil English (R-PA) sponsored a similar bill, H.R. 562. These bills would establish criteria to define what an LTAC hospital is and which patients should be treated there. They would limit the type of patients who can be treated in an LTAC hospital and reduce Medicare spending on LTAC hospitals by $1-2 billion over five years. These bills present a rational way to limit spending on LTAC hospitals, as opposed to the 25% rule that will create unnecessary and uneven hardships for patients and hospitals.

5. A few more examples of harm the 25% rule proposal would cause include:

- Loss of local LTACH services in all but large metropolitan areas
- Fragile patients would have long ambulance rides to access LTACH care
- Families of patients would have long drives to see loved ones in LTAC Hospitals, for over 25 days average hospitalization
- Patients would have to drive past LTAC hospitals with empty beds in their community and drive to another city to get LTAC care, because of the quotas
- The 25% quota does not work in Cities with only 1 or 2 acute care hospitals. There is no place for the first 25% of patients to come from, before the matching 25% from the local hospital can be admitted.
- Constant CMS changes lead to healthcare industry instability
- The constant annual changing of regulations and reimbursement hurts small businesses that are trying to build long term companies that provide quality

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healthcare services to very ill patients. Companies cannot plan for the future when CMS significantly changes the regulations every year.

- Capital commitments have been made by companies to build new hospitals; the 25% rule could cause bankruptcies caused by the inability to service lease payments and guaranties that were required to get the new hospitals built.

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. These policies discriminate against patients in the 26th percentile and higher and patient care will suffer.

The affect of the existing 25% rule and other changes made over the last three years have not been fully documented yet and CMS does not yet have data to confirm that the policy is achieving the stated policy goals and not having adverse effects on patient care. The proposed 25% rule expansion is a draconian quota system that would cause the most harm to patients and LTACHs in rural and underserved areas. This proposal should be dropped, if not for all free-standing LTACHs, at least for areas that have less than 4 equivalent STAC hospitals.

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. In addition, the same rationale for creating grandfathered status for PPS-exempt hospitals that were established before the HIH regulations took effect holds true for freestanding LTACHs under the current proposal to extend the 25% rule to them. If CMS finalizes this policy in spite of strong congressional and industry opposition, all existing and under-development freestanding LTACHs should be grandfathered from compliance with the new rule.

Please consider and decide the following:

1. Not implement a 25% admission limit, if not for all free-standing LTACHS, at least for rural, underserved, and other areas with less than four equivalent sized general hospitals; or
2. If the 25% rule for free-standing hospitals is implemented, permanently grandfather existing and LTACHs and hospitals currently being constructed to become LTACHs.

This would provide sensible governing:

- Companies that have invested in and guaranteed long term hospital leases, based on the rules in existence, would have a chance to survive and meet their obligations.
- Appropriate LTACH patients could receive care in their home town, or closer to home, if an LTAC Hospital is already there.
- Patients could be treated by their own doctor, instead of getting a new doctor in the town to which they have to travel.
- Families could visit their loved one daily without an extra burden of travel, lodging, meals and other expense and burden.

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

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1. ***Overall Payment Adequacy***. The Medicare Payment Advisory Commission (MedPAC) found that LTAC hospital margins are between 0.1% and 1.9% (MedPAC Report to Congress, March 2007). Yet, CMS projects the proposed rule would reduce payments by 2.9%, which results in rates below the cost of care. In addition, CMS's estimate understates the actual impact by approximately 0.9% because it fails to account for the negative impact of raising the high cost outlier threshold by $3,887 per case. CMS should not propose LTAC hospital rates that fall below the cost of care. The proposed rates are neither reasonable nor adequate given Medicare's goal of covering providers' cost of care. Furthermore, payments would be reduced by a much greater percentage for LTACHs serving rural and underserved areas that have less than at least three or four general hospitals.

2. ***Short Stay Outlier Payment Adjustment.*** CMS also proposes to pay LTAC hospitals a reduced rate for "very short stay" outlier cases. CMS again justifies this proposal based on the concern that Medicare should not pay twice for a single episode of care. Less than one year ago, CMS finalized a rule that pays LTAC hospitals no greater than cost for all short stay outlier cases. It is too soon to implement further payment adjustments when the new policy has been in effect for less than one year and the impact has not been assessed. LTAC hospitals have no incentives to admit patients that will be "short stay" when LTAC hospitals are already paid no greater than cost for these patients.

3. ***Market Basket Update***. CMS proposes paying LTAC hospitals a 0.71% market basket update, less than the full market basket update of 3.2%, which represents an estimate of actual cost increases experienced by LTAC hospitals. CMS should provide the full market basket increase, especially in light of other payment adjustments, or the cumulative effect of the proposals results in LTAC hospital rates below the cost of care. Nurse and other staff, supplies, and drug costs continue to increase faster than inflation.

4. ***LTAC Hospital Certification Criteria***. Legislation has been introduced in the Senate (S. 338) and House (HR 562) to revise LTAC hospital certification criteria to implement MedPAC recommendations of over two years ago. Congress has made it clear that revised LTAC hospital certification criteria, not continued payment cuts, is the preferred policy route to address issues of concern. The proposed rule continues a pattern of arbitrary and punitive payment cuts, based upon questionable assumptions and incomplete or outdated data, which will hurt LTACHs and Medicare beneficiaries. An approach that would better serve Medicare beneficiaries would be to work together with the LTACH industry and the Congress to develop new certification criteria to better define LTACH facilities and patients to accomplish this goal and help stabilize Medicare reimbursement to LTACHs.

5. ***LTAC Hospital Growth***. CMS continues to raise concerns about growth in the number of LTAC hospitals. However, the cumulative effect of CMS's recent changes and existing payment policies have halted, and possibly reversed, the growth of new LTACHs, and LTACH margins are estimated by MedPAC to be at or near zero. Growth in the number of new LTACHs has stopped.

6. ***CMS is interfering with patient choice and the practice of medicine.*** The proposed rule greatly restricts patient choice and interferes with the practice of medicine by arbitrarily

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paying LTACHs at the LTACH payment rate for no more than 25% of its patients referred from any one hospital. This policy also violates the agency's own stated goal to place Medicare patients in the most appropriate post-acute care setting. CMS should implement an LTACH PPS that recognizes the medically complex care LTACHs provide and the will of Congress to fairly pay for LTACH services. The Congress, the LTACH industry, MedPAC, and RTI International (which recently provided a report to CMS on LTACHs) all agree that LTACHs serve an important role in caring for medically complex patients who need long-term hospital stays. The combined effect of this proposed rule makes clear that CMS does not agree with this most basic premise. These proposed policies will continue to erode the LTACH PPS by reimbursing LTACHs for fewer and fewer medically complex patients at the LTACH PPS rates.

7. CMS must implement an LTACH PPS that fairly reimburses LTACHs for the costs they incur in caring for Medicare beneficiaries, in keeping with the statutory mandate of Congress. The proposed changes to the regulations will bring LTACH reimbursement below their cost of care

Conclusion

The 25% admission from any one hospital policy will have a desparate impact on LTACHs in areas without at least four equivalent referral hospitals – primarily underserved, rural and other nonurban markets – that is not appropriately accounted for with the limited number of exceptions to the 25% rule. CMS should not extend the current 25% rule, or any similar policy, to freestanding LTACHs or grandfathered LTACHs. However, if CMS finalizes this policy, it should:

(1) Grandfather all existing and under-development freestanding LTAC hospitals from the rule altogether, and
(2) Set the applicable percentage for all new freestanding LTACHs at 50% in light of the lesser policy concerns CMS has with these hospitals as compared to co-located LTACHs, and
(3) Exclude rural areas and other cities with less than 4 equivalent hospitals from the 25% or proposed 50% rule.

Thank you for your attention to the important considerations related to LTAC hospitals raised in this letter.

Sincerely,

Ken Noteboom
Administrator

1210 West Robinson Street
Norman, Oklahoma 73069
Ph: 405-321-8824

cc: Senator James M. Inhofe
Senator Tom Coburn
U.S. Representative Tom Cole

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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 Promise Healthcare Inc.("Promise") 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. Promise operates fifteen LTACHs in six states throughout the country.

Promise believes that, if implemented, the proposed changes to the LTACH PPS will result in arbitrary and inappropriate reductions in LTACH payments. In short, the proposed rule changes suffer from a number of recurring problems. First, as with other recent rules affecting LTACHs, CMS continues to rely upon materially flawed and incomplete data in developing its proposed changes to LTACH payments for RY 2008. Promise'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 implemented. Second, Promise does not believe that CMS has seriously considered the legal and equitable issues the proposed rule raises with regard to patient freedom of choice, physician medical decision-making, and the disparate impact on LTACHs in underserved areas.

PROMISE 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. Promise also supports the recommendations made by the Research Triangle Institute ("RTI") in their CMS sponsored study, to develop severity measures and patient admission criteria to identify patients requiring an LTACH's unique ability to treat medically complex patients. Promise supports these approaches as better methods for limiting LTACH payments to hospitals that are truly caring for a medically complex patient population. Unfortunately, the proposals that CMS advances in the proposed rule continue to rely on arbitrary and unproven payment reductions to achieve policy goals and in many cases will significantly hinder the ability of LTACHs to continue to provide quality patient care to Medicare beneficiaries. Arbitrary payment reductions do not encourage quality of care.

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. Concerns about inappropriate admissions should be addressed by relevant measures, 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, Promise 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.

The proposed policies and reimbursement changes in the proposed rule will have a direct, adverse impact on the LTACHs operated by Promise and the Medicare beneficiaries they serve.

A. Promise's Response to the Expansion of the "25%" Rule

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 only became effective in 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 short-term acute care hospitals ("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 seen evidence of that at our facilities and believe that the analysis developed by ALTHA in its comment letter to you supports this industry-wide view. Our LTACHs do not act as extension sites or units of STACHs.

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 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 its assumption is the percentage of referrals that LTACHs receive from primary referral sources. The data, taken alone, do not support the conclusion that Medicare is paying twice for a single episode of care.

(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 LTACHs 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) Hospital Discharge and Referral Relationships Are Required by Law and Are Not Evidence of Inappropriate Admissions, to the Contrary, Frequent Discharges and Referrals Between Hospitals May Be an Indicator of Superior Patient Care.

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

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

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, determine 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).

The law refutes CMS's presumption that LTACHs are merely functioning as units of other hospitals simply 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.

CMS and JCAHO surveyors at our facilities have emphasized that patient discharge and referral are aspects of care that require great vigilance and sophistication. Since it is universally accepted in quality circles that better outcomes are achieved when complex procedures are performed frequently, CMS should take comfort, not concern, when patient discharge and referral between hospitals is the practice and not the exception. We have substantial anecdotal evidence to support this view and would welcome further analysis by CMS.

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

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, as described in Table 1 below, 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**
All Discharges				
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%
Discharges to LTACH				
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%
Discharges to Other Destinations				
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 three-day or less interruption of stay policy, and the post-acute transfer/discharge policy. It is 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 merely duplicating 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 four days longer than the geometric mean length of stay for patients in the same DRGs. It is 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 Prior to Completing Episodes of Care to avoid High Cost Outlier Status.

Although not specifically discussed in the rulemaking record, ALTHA conversations with CMS revealed that another possible justification for the proposal to extend the 25% rule to freestanding LTACHs is the concern that Short Term Hospitals 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. Promise support's ALTHA's analysis of MedPAR 2005 data that shows the opposite: there is no relationship between the percentage of high cost outlier cases in acute care hospitals and the percentage 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.

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

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 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 common DRGs assigned to patients in STACHs who are ultimately sent to LTACHs. There are only six DRGs in the top one hundred 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 twenty-five 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 three 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 three DRGs, the case counts are very different, which further rebuts CMS' assumption that there is a single episode of care.

Table 2

LTACH Rank	DRG	DRG Description	LTACH PPS Frequency	IPPS Frequency	IPPS Discharge to LTACH Rank
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

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 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).

Total	136,226	112,163

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 from what they received when they were discharged from the LTACH.

(7) 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 decision-making."[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. In fact, Promise re-located its hospital in Nederland Texas, not to avoid co-location concerns, but for the opportunity to address the needs of more medically complex patients by providing an ICU level of care. The same reasoning is behind its planned relocation of its facility in Ferriday, Louisiana.. It is co-located with a nursing home in its current setting, but the building is not equipped to support the level of care required by intensely ill, medically complex patients. 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

[3] 5 U.S.C.S. § 706.

[4] Id. § 706(2)(A).

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

[6] Id. at 52 and 57.

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 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.

We believe the proposed rule does nothing to improve the efficiency of the Medicare program or ensure that Medicare beneficiaries obtain the best services possible for the resources spent by the program. CMS should focus its resources on enforcing its existing requirements for HIHs at 42 C.F.R. § 412.22(e), rather than take the premature step of expanding this payment penalty to freestanding hospitals. Until the transition period for the HIH 25% rule is completed for all 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.

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 October 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. Furthermore, the penalty CMS is advancing will not be limited to LTACHs as it will adversely impact other acute and post-acute providers who are forced to care for these patients.

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. Promise operates a freestanding LTACH in Vicksburg, Mississippi, the southern tip of the Mississippi Delta region. The *only* STACH in the area is River Region Medical Center. Understandably, more than 80% of our LTACH's referral come from River Region. A 50% rural "safety net" would still require three of every ten patients who required LTACH care to be transferred more than 40 miles away to Jackson, Mississippi. They would be treated by unfamiliar physicians and likely cut off from family visitors who would find that trip too arduous. A 50% rule will limit access to patient care, restrict patient choice, and trump medical decision-making. Rural communities will have substantially less access to LTACH services than urban areas. Patients in the fifty-first 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 rural LTACHs will have a compounding effect, regardless of the higher percentage that may be admitted before the payment limitation applies. Rural areas have fewer STACHs and LTACHs and patients who must travel greater distances to reach local health care providers. Expansion of the payment limitation will cause an undetermined number of patients in underserved areas 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 is a rural payment penalty 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 Social Security Act ("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 ("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, the proposed rule change 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.

The proposed rule change is also discriminatory against patients in the twenty-sixth 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 twenty-sixth percentile and higher. Patients in the twenty sixth 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 a few among the many unintended consequences of this policy proposal. In addition to restricting access to care and discriminating against patients seeking services later in an LTACH's cost reporting year, the proposed rule will result in the lengthy continuation of care in STACHs or discharges to different types of post-acute care providers that are not equipped to provide the services or level of resources that are necessary to improve the condition of high-severity, medically complex patients. These are legitimate concerns that CMS cannot ignore by simply stating that this is a payment policy. If this were simply a payment policy, it would not establish patient quotas for the reasonable reimbursement at the LTACH PPS rates for only a small fraction of all LTACH discharges.

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.

Promise LTACHs admit patients only after applying InterQual's objective and rigorous set of admissions screening criteria. To confirm this, Medicare QIOs conduct post-admission reviews of LTACH patients to ensure that an 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 no definitive document or set of documents that LTACHs 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 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.

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. In addition, the same rationale for creating grandfathered status for PPS-exempt hospitals that were established before the HIH regulations took effect holds true for freestanding LTACHs under the current proposal to extend the 25% rule to them. If CMS finalizes this policy in spite of strong industry opposition, all existing and under-development freestanding LTACHs should be grandfathered from compliance with the new rule.

h. 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, Promise 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.

2. Promise 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.
- Not revoke grandfather status for HIHs currently afforded grandfather status.
- Set the applicable percentage for all freestanding LTACHs at 50% in light of the lesser policy concerns CMS has with these hospitals as compared to HIHs and satellites and expand rural exemptions to 75%.
- 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.

B. Promise's Response and Recommendations to the Short Stay Outlier ("SSO") Policy Proposal

1. PROMISE 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.

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 LTAC 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 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 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.

Assuming 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 not the same kinds of patients. ALTHA's 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 the 10 most common LTACH cases, the VSSO 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

[7] For purposes of this letter, PROMISE 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 PROMISE'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.

DRG	DRG Description	STACH ALOS	STACH SOI 3 & 4 %	LTACH ALOS	LTACH SOI 3 & 4 %	VSSO ALOS	VSSO SOI 3 & 4 %
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	13.9	96%	38.3	94%	10.1	94%
271	SKIN ULCERS	11.8	43%	29	74%	7.8	74%
87	PULMONARY EDEMA & RESPIRATORY FAILURE	7.7	72%	29	91%	6.7	87%
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	8.5	62%	23.9	79%	8.7	73%
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	5	26%	20.6	60%	5.4	51%
249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	10.2	10%	25.1	41%	6.2	28%
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	5.6	44%	21	75%	5.5	70%
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	6.1	24%	28.5	49%	9.3	43%
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	17.5	17%	22.7	54%	10.3	43%
462	REHABILITATION	12.4	36%	22.6	52%	11.6	45%

Table 3 illustrates the significant difference in SOI in VSSO cases compared to STACHs. As PROMISE 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 3 indicates. Because these cases are clinically similar to other LTACH cases, PROMISE believes it is appropriate for CMS to pay for them under the LTACH PPS.

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 twenty-five 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 thirteen 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 ninety-six hours. DRG 565 patients staying twenty-three days are just below the IPPS comparable threshold but can not be described as short stay patients with a stay so close to the twenty-five 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.

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 two 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.

The policy would create an even larger payment cliff for patients with a LOS longer than twenty days (but below the IPPS threshold). MedPAR data indicate that the average payment reduction for the 350 VSSO cases with a LOS over twenty 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 twenty 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 does not adequately justify paying for these cases under a methodology that would systematically pay at or, in most cases, below cost. CMS PPS systems are designed to pay according to resource use. Case arbitrarily defined as very short stay outliers would not be paid according to their LTACH resource use under the proposed policy. Promise can not support paying for a majority of a type of case at below cost, especially since the only justification is the length of stay of that case. As discussed above, ALTHA's analysis demonstrates that these cases are clinically similar, based on severity of illness scores, as other LTACH 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 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, Promise's 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 twenty-five 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 twenty-five 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 length of stay of 50% of patients are above and 50% are below, then taking 5/6th of the GMLOS will consistently produce a percent of patients that is around 42%. That is, 5/6th of 50% is always 42 percent. As the LOS change each year and the GMLOS is recalibrated annually, the 5/6th measurement factor will continue to produce the same percent of patients below that level. In light of this fact, it is apparent that the 37% 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 5/6th of the short-term hospital GMLOS.

2. Promise's Position

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. Promise 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 twenty-five days.

C. Market Basket Increase and Overall Payment Adequacy

1. Promise's 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 re-weighted 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 4 below). Promise 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 4

RY 2008	**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, ALTHA estimated two cost levels (upper bounds and lower bounds) to account for both margin scenarios.

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." <u>See</u> 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 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%. Promise 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 of the market basket; 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]

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 states that payment is calculated at:

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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.

(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. 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. Between 2005 and 2006, Promise has experienced a 5.6% increase in its operating cost per patient day with a 0.6% decrease in revenue during the same period. A market basket increase of 0.71% is grossly inadequate to cover the increased resources needed for patient care.

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 section 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.

Promise 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, Promise 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. We support 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. PROMISE 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 practices 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 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. PROMISE 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 5

Rate Year	Fixed-Loss Thresholds	Base Payment Amount
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, ALTHA 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). ALTHA 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 [xx] below, the effect on the number of cases was more striking than the reimbursement effect.

Table 6

High Cost Outlier Data (2005 MedPAR)	
LTACH Cases	136,289
HCO Cases	12,883
Mean HCO Payment	$21,752
Impact of Proposal	
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

2. PROMISE 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. Promise's 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 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 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.

2. PROMISE Position and Alternatives

PROMISE 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. Promise's Response

PROMISE supports CMS's proposal to establish a budget neutral requirement for the annual reclassification of the LTC-DRGs and recalibration of relative weights. 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.

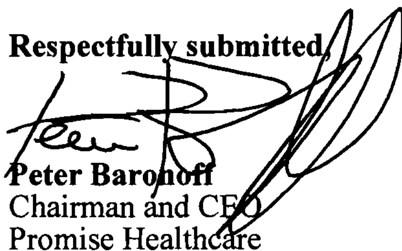
2. Promise's Position and Alternatives

PROMISE supports this change in policy as a necessary step to bring the LTACH PPS more in line with the IPPS budget neutrality requirements. It is also included in the bills before the United States House of Representatives (H.R. 562) and Senate (S. 338).

II. Conclusion

Promise believes that CMS' proposed programs and payment changes are to a great degree, as described above, arbitrary, punitive, and in many cases wholly unsupported by data, facts, or need. CMS should reject the proposed changes to the 25% rule; SSO payment methodology; and limited market basket increases and instead adopt the recommendations of MedPac and RTI for more efficient care for Medicare beneficiaries.

Respectfully submitted,



Peter Baronoff
Chairman and CEO
Promise Healthcare

March 22, 2007

Ms. 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; 2008 Proposed Update Rule Published at 72 Federal Register 4776 *et seq*.

Dear Ms. Norwalk:

Youville Hospital & Rehabilitation Center ("Youville") 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. Before we begin our comments, we call to CMS' attention the comment letter submitted by the National Association of Long Term Hospitals (NALTH) and the report by the Lewin Group included as Appendix A to NALTH's letter. We incorporate some of NALTH's and Lewin's findings in our comments. We have also included Youville- specific statistics to the extent that our internal analysis has been completed to apply the proposed rule changes to of Youville's Medicare discharges.

Youville was established in 1895 and is located at 1575 Cambridge Street, Cambridge, Massachusetts. Approximately 65% of Youville's patients are Medicare beneficiaries who reside in the greater-Boston metropolitan area. Youville strongly opposes CMS' proposed expansion of the 25% rule to freestanding and grandfathered hospitals and its consideration of an expanded short stay outlier ("SSO") payment policy to allow "extremely" SSO cases to be paid comparable to Inpatient Prospective Payment System (IPPS) cases. Both rule changes are

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unsupported by facts and contradictory to physician-driven, patient-centered clinical decision-making. The two proposals would drastically reduce total Medicare payments to Youville during fiscal year 2008 by up to 5.5%; the total estimated reduction to Youville could be just under 7.0% when the market basket percentage, increased high-cost outlier threshold and revised area wage index formula are factored in. The exact reduction is difficult to quantify due to variation in admission patterns from area acute care referral hospitals. These changes will force Youville to operate at a significant loss when treating Medicare patients, which is consistent with the Lewin Group's estimated industry margins (see Lewin Report, Exhibit II.B-2b). Youville urges CMS to not adopt the proposed expansion of the 25% rule and to reject the extreme SSO policy because the continued ability of Youville Hospital to serve its patients will be placed in jeopardy if they are adopted.

In the preamble to the proposed update rule, CMS repeatedly justifies these two proposals with generalized, unsupported, and mistaken statements that LTCHs behave like IPPS acute care hospitals (ACHs), that LTCHs act like ACH step-down units, or that ACHs are discharging patients to LTCHs during the same episode of care. In fact, LTCHs do provide different services to patients and LTCH patients do utilize different resources than ACHs, thus making CMS' proposal to pay LTCH discharges under the IPPS inappropriate. CMS has presented no data to support its proposals other than presumptions and beliefs. CMS' own contractor, Research Triangle Institute (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 NALTH's comment letter, physicians at ACHs use their expertise and experience to discharge certain patients to LTCHs because the specialized care provided by LTCHs is clearly in the best interests of the patient. In general, ACHs are "diagnosis focused" and provide critical care focused on a single clinical dimension. Youville, however, provides the complete array of team-based services that focus on multiple dimensions, i.e. the recovery of the whole patient. Youville helps patients recover all functions (both cognitive and physical) and return to the community. ACHs simply are not designed to provide these services, and no incentives currently exist for them to replicate Youville's specialized

services. To delay (or eliminate entirely) a patient's transfer from an ACH to Youville purely for payment system reasons, and thus delay (or eliminate entirely) the provision of needed specialty services is punitive and could jeopardize the patient's potential for full recovery.

CMS has offered no support for its generalized statements that patients in LTCHs should be paid comparably to patients in ACHs. In fact, The Lewin Group has demonstrated that SSO patients in a LTCH cost far more than patients with the same DRG in an ACH, and their lengths of stay in a LTCH are more than double those with the same DRG in an ACH (See Lewin Report, section II.D.1). LTCH patients, and certainly Youville patients, are not equivalent to ACH patients.

Expanded 25% rule

CMS justifies expansion of the 25% rule to all LTCHs on the presumption that an ACH discharge to a LTCH is a "presumably premature discharge" if the patient had not reached cost outlier status at the ACH. However, CMS has provided no clinical or financial analyses to support this conclusion. Rather, the 25% rule would establish a litmus test for LTCH admission based on the patient's costs at the ACH and how many other patients were previously admitted from that same ACH. On the other hand, NALTH has presented significant clinical and financial evidence that ACH patients are discharged based upon the ACH physician's expertise; the physician determines when patients are appropriate for transfer to Youville based upon the patients' condition, medical needs, and availability of appropriate services in order to maximize the patient's recovery. Additionally, RTI concluded that it cannot state that LTCHs substitute for services already paid to IPPS hospitals. Given CMS' lack of evidence to the contrary, its proposal should be withdrawn.

The 25% rule would be administratively impossible for Youville to implement. Youville typically does not know if an ACH patient had achieved cost outlier status during his/her ACH stay because:

- Youville generally does not know the patient's IPPS DRG assignment

- The ACH does not know if the patient has achieved cost outlier status because the patient's discharge bill has not yet been processed
- Youville would not know if the patient's ACH DRG were changed upon review by the Quality Improvement Organization (QIO)

Also, calculation of the 25% limit cannot occur until year-end, when the total number of Medicare cases is known. The 25% rule contradicts the basic concept of a *prospective* payment system by instituting a retrospective payment settlement. Such a settlement would be very difficult, if not impossible, for Youville to accurately estimate on an ongoing basis for the purposes of accurate financial reporting.

Furthermore, the proposed expanded 25% rule fails to recognize the many localities in which LTCHs serve a small number of independent ACHs. These LTCHs cannot satisfy the 25% rule, simply due to the limited number of potential ACH referral sources, regardless of any ability they may have to influence referral patterns. Even in the greater-Boston metropolitan area, which includes several tertiary-care teaching hospitals and many large community hospitals, Youville would find itself penalized under the 25% rule. Also, Youville questions the basis of the 25% threshold itself. CMS has presented no statistical basis for applying an arbitrary number throughout the country to penalize LTCHs.

Expanding the 25% rule and, thus, the rule's severe payment penalties to all LTCHs will jeopardize Medicare beneficiaries' access to appropriate medical care. Payments under the 25% rule will fall far short of the actual cost of providing care to those beneficiaries. At Youville, the average payment per case is estimated to decline by $14,300 (from $26,700 to $14,400), or 53.5%. These cases had an average length of stay of 26.6 days; the 25% rule payment equals a mere $467/day. Such severe payment penalties will virtually direct LTCHs to admit no more than 25% of their Medicare patients from any single referral source. Additionally, the significant and inappropriate financial losses generated by this rule will force the closure of a significant number of LTCHs, thereby further preventing access to these unique and necessary services by Medicare beneficiaries.

Extreme SSO policy

Youville strongly opposes the extreme SSO policy as being both unnecessary and unjustified. Under the current SSO policy, Youville receives only its cost, *or less*, for a SSO; Youville has no incentive to admit a patient who may become a SSO. The extreme SSO policy would impose further financial losses on Youville by ensuring that large numbers of SSOs would be paid below cost. Youville estimates that approximately 34% of its SSOs would be paid under the extreme SSO policy, which represents about 15% of Youville's total Medicare cases. Payments for extreme SSOs would be reduced by approximately 3.2% from current payments.

All patients, including SSOs, are admitted to Youville at the appropriate level of care based on their physicians' medical judgment. CMS assumes that LTCHs can predict, at the time of admission, which patients will become SSOs. However, Youville has no way to make such a prediction, much less which patients may become extreme SSOs. Youville's patients experience multi-system body failures and their conditions may unpredictability improve or deteriorate at any time. A Youville patient may become a SSO for myriad reasons:

- Achieves medical stability sooner than originally expected.
- Requires discharge to an ACH due to a deteriorating condition or a new condition which develops subsequent to their Youville admission.
- Exhausts Medicare Part A benefits prior to achieving $5/6^{th}$ geometric mean length of stay.
- Unexpected death.
- Requests that aggressive treatment be stopped after Youville admission.
- Signs him/herself out against medical advice.

Similar to the proposed expanded 25% rule, the extreme SSO policy lacks any clinical or financial analyses to support CMS' assertion that SSOs should have remained in the ACH. It ignores the physician's judgment in determining which patients would benefit from the unique services provided by Youville. If adopted, this policy will further jeopardize Medicare beneficiaries' access to appropriate medical care.

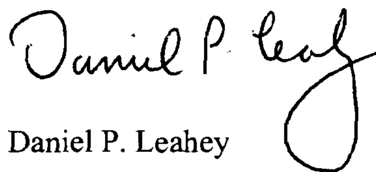
Conclusion

The proposed expanded 25% rule and extreme SSO policy intrude upon physician decision-making and are contrary to long-standing Medicare principles that govern medical necessity determinations. CMS has ignored MedPAC's recommendation contained in its June 2004 report to Congress that CMS designate QIOs to review the medical necessity of LTCH patient admissions. Although QIOs are best able to determine the medical necessity, reasonableness and appropriateness of LTCH admissions, CMS has proposed arbitrary and punitive payment rules to limit LTCH admissions. Each rule would impose a payment reduction mechanism to disqualify a patient for LTCH services, thus limiting a beneficiary's access to the specific LTCH programs of care and services which have been deemed most appropriate for that patient.

The proposed rulemaking should also be considered in the context of the final rule for RY2007, which was estimated to result in a 7.1% reduction in payments to LTCHs. As a result of this reduction, implemented in July 2006, Youville has experienced a 3.5% operating loss in the current fiscal year. Further reimbursement cuts in RY2008 will seriously jeopardize Youville's continued ability to minister to the health care needs of the community which it has strived to serve for over 110 years.

In view of the foregoing, Youville 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,



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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.

Establishing a 25 percent admission cap for all LTCHs

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 eliminate 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

Madonna
Rehabilitation Hospital

TherapyPlus
Outpatient Services

Rehabilitation Specialists
Physicians Group

Research Institute
Rehabilitation Science & Engineering

St. Jane de Chantal
Extended Care Services

Foundation
Supporting Madonna Rehabilitation Hospital

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

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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. 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.

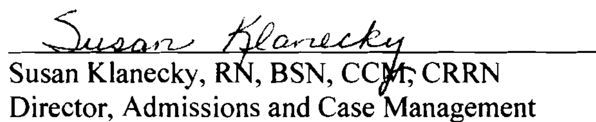
Madonna recommends that CMS increase its review of the medical necessity of Medicare beneficiary admissions to LTCHs and initiate review of the medical necessity of continued patient stays. This would start to address concerns raised by MedPAC as to the appropriate placement of patients in LTCH.

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.

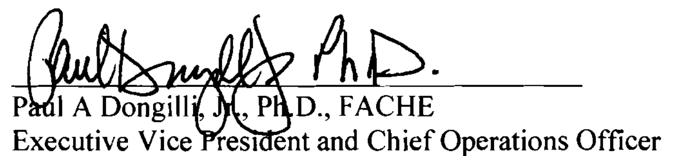
The above recommendations would re-align CMS' policies to a patient-centered approach versus imposing payment reductions as a mechanism to regulate patient access to LTCHs, and would result in new Medicare program savings.

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

NOLAND HEALTH SERVICES, INC.

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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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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

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von Briesen & Roper, s.c. | Attorneys at Law

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March 23, 2007

VIA FEDERAL EXPRESS

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1529-P
Mail Stop C4-26-5
7500 Security Blvd
Baltimore, MD 21244-1850

Re: PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION
Comments on Proposed Rule, 72 Fed. Reg. 4817, February 1, 2007
File Code CMS-1529-P

Dear Administrator:

On behalf of Appleton Medical Center and St. Elizabeth Hospital in Appleton, Wisconsin, who support the University of Wisconsin Fox Valley Family Medicine Residency Program, thank you for your efforts toward developing a reasonable solution to the difficult problem of satisfying the statutory standard for non-hospital locations without an unworkable data-collection burden. Adopting a regulation defining "all or substantially all" to equal 90 percent of resident and teaching physician costs, and allowing specific proxies for some of the more hard-to-obtain pieces of documentation necessary to meet the standard, are significant developments. We particularly appreciate that you moved forward with this off-cycle, so that programs can have the benefit of the new rule and guidance sooner than the next acute HIPPS rulemaking.

Our comments relate to the guidance in the preamble. We have attempted to apply the proxies and related guidance to our program, and we have discovered issues we would like you to address. While the proxies you have identified are a start, they can be made to fit more closely with common situations – and with other Medicare requirements – so that they are significantly more implementable, and thus in keeping with Congress's intent to allow payment for training in non-hospital sites.

Information Regarding Fox Valley Family Medicine Residency Program

Our program is much like other family practice programs in communities that do not have a medical school and affiliated academic hospital. In Appleton, two hospitals – which are otherwise competing – have jointly supported this program as being beneficial to the community. Each hospital has historically passed on virtually all of its Medicare GME/IME reimbursement to the Program, in spite of the fact that the hospitals incur their own costs for education occurring within the hospitals. The Program has 18 residents enrolled per year, constituting 6 residents for each of the 3 resident year levels.

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The primary site for resident training for this program is a University-owned clinic (non-hospital) location in which teaching physicians maintain their family practices, and residents work with them, including in ongoing continuity clinics. Continuity clinics are maintained on an ongoing basis for all residents for their entire training, as required for ACGME certification. For FTE counting purposes, time spent at this main location runs about 6.45 FTEs per year. A significant feature of family practice training is that residents must also train with specialists. In order to secure that training, the Program has traditionally relied on the volunteerism of local specialists who are not otherwise affiliated with the University. Residents rotate to approximately 35-40 sites each year, to train with over 50 specialist physicians. These rotations account for approximately 4.63 FTEs per year. Note that the FTEs countable at the specialty sites are lower than might be expected based on the rotation schedule, because each resident spends half-days at the UW continuity clinics.

The Program runs on a very tight budget. Its budget was tight before Appleton Medical Center lost nearly 4 FTE slots as a result of MMA 422, and now the Program is in serious financial straights. As such, it faces a significant challenge: take money away from the Program to pay physicians (who do not want the money), or risk its reimbursement under the hospitals' cost reports. Every penny that goes to a physician comes out of the Program, and increases the chance that the training Program will have to be curtailed. It should also be noted that significant time is being spent by Program staff to gather survey data and other information about the physician practices, to calculate payments, and to make sure they get sent in time to comply with the regulations. This is time that used to be spent in education activities.

In the past, we have sought guidance from CMS regarding methods to comply with the rules for paying these non-hospital sites. Since CMS has not changed the requirements regarding determining actual costs, beyond stating that only 90% of those costs must be funded by the hospital, we understand that the past guidance would still apply. We attach for your reference a letter which we believe summarizes CMS's position on documentation, based on conversations with CMS staff. If CMS no longer agrees with our summary, please provide more specific information regarding documentation requirements in the Federal Register.

One other point deserves to be mentioned. Virtually all of the community physicians are referral sources of the hospitals. Until recently, we had believed that compliance with Medicare guidance regarding paying these supervising physicians would be considered by CMS to be in compliance with Stark law. Please confirm in your commentary that a reasonable attempt to comply with the requirements to pay for costs at non-hospital sites, whether it be under the written agreement standard or under the concurrent payment standard, using proxies or real costs, is considered by CMS to be fully compliant with Stark law. If CMS believes that following its guidance – including all of the compliance options – will not allow hospitals to be fully in compliance with Stark requirements, then we request that CMS make an exception for payment to non-hospital sites where the payments are to referring physicians.

We have several comments regarding the proxies you recently proposed. We believe addressing these issues will make the Program much more implementable, and will target payments more narrowly to actual reasonable costs. For us, we also hope that implementing this guidance will mean that more money can be maintained to train residents, rather then spent on volunteer specialists.

Three Hours Supervision Time Proxy

In our program, we surveyed the community supervising physicians. These are the physicians who are not employees of the University, and who individually agree to supervise the residents in their private practices. Our survey closely followed the CMS definitions of the time that must be counted to determine supervision costs. We included 4 categories of time, with only the last two being countable for cost-determining purposes (we counted teaching not related to the diagnosis or treatment of an individual patient and resident evaluation and other administrative time). A copy of the survey is attached for your information. Out of 54 responding physicians, the average response was 1.45 hours per one-week rotation. The range of responses was from 0 to 6 hours. Based on this data, we suggest that CMS lower its proxy to 1.5 hours per week.

Salaries of Supervising Physicians

We appreciate being offered a proxy number for physician salaries. This piece of data is in fact impossible for us to get from many of our community physicians, so a proxy makes compliance and payment possible, where before it simply was not. What we find troubling is that the proposed salary proxy is not RCEs. As hospitals, we understand that CMS has determined that RCEs are the limit of reasonable compensation for physicians, and we are usually not allowed to include payments to physicians for Part A services on our cost reports in excess of those amounts. GME payments are also Part A payments. We believe CMS should be consistent in how it defines what is a reasonable payment for physician services furnished in a Part A context. We also note that RCEs are familiar and accessible to hospitals, are regularly reviewed and updated by CMS, and are not controlled by a private, non-governmental entity. These factors make RCEs more appropriate than privately-developed standards.

Pro-Rating Issue

We understood from the proposed rule commentary that physician salary cost would be pro-rated on an FTE basis. Since GME FTE counting is usually done in fractions of days when we are audited by our contractor, we understood this to mean that physician salaries would be pro-rated based on countable FTEs at the non-hospital site. At a recent conference, however, a CMS representative indicated that was not CMS's intent. Instead CMS meant that physician salary could be pro-rated by the WEEKS a resident is at a site, but NOT for any half-days. We regret that CMS is taking an inconsistent position on pro-ration for paying physicians compared to counting resident FTEs.

Not allowing pro-ration for half-days will result in significant over-paying of physicians. On most days, our residents are at two non-hospital sites. Under ACGME standards, our residents must work substantial hours (usually half-days) at their continuity clinics at the UW clinic location. We are required to pay substantially all of the costs of teaching physician salaries at both sites. Under the proposed standard, if we use proxies (which for some physicians we must do, since some will not respond to surveys), we will have to pay for full-time supervision twice for the same resident week. This is double-paying physicians. Considering the significant concerns CMS and OIG have with hospitals over-paying referring physicians, we do not understand why CMS believes hospitals must pay for two FTEs worth of supervision where only one exists. This is paying twice the costs. Consistent

with how FTEs are counted for other GME purposes, we request that CMS allow us to pro-rate physician salaries to account for the true count of FTEs at these sites. This would allow us to pay appropriately, regardless of whether a resident spends a full week, a half-day each day for a week, or only selected days in a week, at a particular nonhospital site.

Effective Date

While we urge that the proposal be revised to account for these comments, we also request that CMS make the 90% standard and proxy option available to hospitals as of July 1, 2007. Everything relating to GME documentation must be done on an academic year period, or it is too difficult for the Program to implement. If the effective date is for cost reporting periods starting after then, most programs will not be able to use the rules for a year or more. Further, with GME issues, there is often a mismatch between the Program's academic year, and the claiming hospital's fiscal year. Hospitals and contractors are accustomed to dealing with standards and documentation rules or arrangements that change during a hospital's cost reporting year. Of course, any hospital that chooses not to take advantage of the new options due to administrative considerations would have the option of waiting until the start of its next cost reporting period to do so.

Thank you very much for considering our comments. If you have any questions regarding our comments, please feel free to contact me.

Very truly yours,

von BRIESEN & ROPER, s.c.

Leslye A. Herrmann

LAH:jmy

Enclosures

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43 attachment

von Briesen

von Briesen & Roper, s.c. | Attorneys at Law

TAGLaw International Lawyers

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October 12, 2005

VIA E-MAIL:
Tzvi.Hefter@cms.hhs.gov

Tzvi Hefter
Director, Division of Acute Care
Centers for Medicare and Medicaid Services

Re: Application of Non-Hospital Site Documentation Requirements to UW Fox Valley Program Appleton Medical Center, Inc. and St. Elizabeth Hospital, Inc.

Dear Mr. Hefter,

Thank you very much, and thanks to all your staff, for spending the time on Friday to provide guidance regarding the documentation requirements. We also appreciate your offer to review a summary of our discussion. Below, we describe our understanding of what is necessary for our program, based on our call.

The University of Wisconsin Fox Valley Family Practice Residency Program ("Program") is accredited through the University of Wisconsin ("UW"), which also employs all residents for the Program during all rotations. Residents have hospital rotations at Appleton Medical Center and St. Elizabeth Hospital. They also rotate to various non-hospital sites, including UW's own clinic, clinics of physicians affiliated with the hospitals, and clinics of non-affiliated community physicians (some of whom are solo practitioners). The hospitals claim both the hospital and non-hospital FTEs for GME reimbursement on their cost reports, and provide substantial support to the Program.

Medicare rules allow counting of GME FTEs for rotations to non-hospital sites under the following circumstances:

1) There is a written agreement between the hospital and the non-hospital site that states that the hospital will incur the cost of the resident's salary and fringe benefits while the resident is training in the non-hospital site and the hospital is providing reasonable compensation to the non-hospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the non-hospital site for supervisory teaching activities.

2) In the alternative, as of October 1, 2004, the hospital must pay all or substantially all of the costs of the training program in a non-hospital setting(s) attributable to training that occurs during a month by the end of the third month following the month in which the training in the non-hospital site occurred.

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42 CFR §413.78(e). We will refer to these two alternatives as the "agreement method," and the "quarterly payment method" for purposes of this letter. A hospital may use the agreement method for some non-hospital FTEs, and the quarterly method for others, as it sees fit. In either case, the hospital must in fact pay all or substantially all of the costs for the program in the non-hospital sites. For locations using the agreement method, this means that there may be some adjustment necessary after the period covered by the agreement, if the costs were in fact greater than the dollar amounts specified in the agreement.

The issue for our call was determining how to arrive at and document the non-hospital costs for the various sites involved in our Program. Our main issue was how to determine teaching supervision costs. There are two variables in determining teaching supervision costs: 1) time spent by the physician, and 2) the costs to the physician's employer (not including "lost opportunity") for that physician's time, based on the physician's compensation. Where the physician is a solo practitioner, defined as a physician who is paid solely based on his or her personal productivity from services personally performed, then there is no teaching supervision cost. For other physicians, the cost must be ascertained.

Regarding the time component, you agreed that could be determined by means of physician surveys. Acceptable surveys would request physicians to identify the portion of their time which is spent doing resident training and supervision, defined as follows:

- Discussions with a resident about patients beyond the time that the physician would have spent on the patient if the resident were not present;
- Didactic teaching, such as presentations to or conferences with the resident without reference to a particular patient; and
- Administrative teaching activities, such as time to schedule resident rotations, complete evaluations of resident performance, or conduct any other administrative tasks in connection with the residents' rotation.
- The definition EXCLUDES time spent in the presence of a patient, and time spent outside the presence of a patient that the teaching physician would have spent even if the resident were not present, such as time spent ordering tests, making entries into the medical record, or working with staff regarding procedures or tests being ordered.

For non-hospital sites using the agreement method, surveys may be the basis for the prospectively determined agreement amount, and there is no requirement that the time be verified at the end of the agreement period. For sites using the quarterly payment method, surveys can be used that were taken during previous quarters.

Regarding the physician compensation component, we expressed our concern that it would be inappropriate for antitrust reasons for the physicians and their employers participating in this Program to exchange salary information. We requested that instead the hospitals be allowed to use Medicare RCEs (which limit Medicare physician reimbursement in other areas) rather than actual compensation. You were not able to answer this question today, but stated you would ask the Medicare audit group and get back to us.

A potential situation that concerns us is a physician who replies that he or she spends no time with residents or performing other Program-related tasks that is not also patient care time. This would result in zero payment to the physician. Would that be acceptable to CMS? You replied that, yes, it would. It

would be hard for a fiscal intermediary to believe that there is no teaching physician supervision time across numerous physicians, however. That would bring into question the integrity of the Program, or of the physicians' responses.

We also discussed particular arrangements that might be put in place by our Program, each of which you agreed would be acceptable for the sites described therein:

1. For UW, if the agreement method is chosen, UW would enter into an agreement with each hospital, which would:

    - identify resident salaries and benefits for non-hospital rotations to be claimed by that hospital (including rotations at all non-hospital sites being claimed, not just the UW site, since UW employs all residents), and require that those salaries and benefits be paid by that hospital;
    - for the hospital claiming the rotations to UW's clinic, identify UW's teaching physician supervision costs, in dollars, based on a physician survey and salary information (or RCEs), and require that those costs be paid by that hospital; and
    - include a requirement that UW identify to the hospital any costs it incurs that are greater than those specified (lower costs could also be reported allowing a credit to the hospital, if the parties agree). This reconciliation would take into account such things as cancelled rotations, or other changes in the scheduling of residents.

2. The differences between the agreement method and the quarterly payment method for UW arrangements are that, under the quarterly method, no prior writing is necessary, and no amount need be determined in advance. The payment must be related to actual costs, however, and so documentation is required, in terms of physician survey information and compensation (or RCEs) to support teaching supervision costs, and documentation of resident salaries and benefits. Rescheduled or cancelled rotations should be accounted for, but quarterly surveys are unnecessary.

3. For solo practitioners, no agreement is required. If one is used as the sole documentation regarding this site, it would have to note that resident salaries and benefits are being paid by the hospital, by means of payments to UW. It must also include a declaration that the physician is a sole practitioner (as defined above), and that thus no teaching supervision costs are incurred. If the quarterly payment method is used, then no agreement is necessary, but written documentation from the physician is necessary to document that he or she is a solo practitioner (as defined above). As in all cases, the hospital would maintain documentation that it paid resident salaries and benefits to UW, based on costs furnished to it by UW.

4. For other physician practices, if the quarterly payment method is used, then no prior agreement on amount of payment is necessary, but the payment must be made timely, and must be for actual costs incurred, as determined by survey for time, salary (actual or RCE), and any adjustments to that data necessary based on changes in the rotation schedule. The hospital would also have to document that it paid resident salaries and benefits to UW, based on costs furnished to it by UW.

Please reply to this letter to let us know whether our description of the requirements, and their proper application, is correct. Thanks again for all your help.

Very truly yours,

von BRIESEN & ROPER, s.c.

Leslye A. Herrmann

cc: Dennis Barry, Esq.

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University of Wisconsin
SCHOOL OF MEDICINE
AND PUBLIC HEALTH

Fox Valley Family Medicine Residen
Department of Family Medici
Appleton, \

September 14, 2006

[redacted], MD
[redacted]
Neenah, WI 54956

Dear Dr. [redacted]

As many of you know a substantial amount of funding for residency education is allocated through the Federal Government in GME dollars. There have been a multitude of policy changes and interpretations that requires the Fox Valley Family Medicine Residency Program to track teaching hours as defined by CMS.

We have enclosed a survey so you can attribute hours related to various teaching activities you engage in on a weekly basis. As a frame to help you calculate hours per week with each teaching area we have enclosed the average contact hours you have per week with residents based year of resident training. Based on the results of this survey, you or your organization may receive some payment for teaching time.

Average Preceptor Contact Hours/ week
1st year Resident = 28-32 hours per week
2nd year Resident = 24-28 hours per week
3rd year Resident = 20 hours per week

The attached survey will be used as a tool to calculate any possible dollar amount for payable teaching activities. We request that you answer the survey as accurately as possible as it is essential that we document this information to remain in compliance with CMS requirements. CMS currently classifies payable teaching time as any teaching that takes place that is not related to patient care. This survey on teaching hours will help us define those hours.

I want to thank you in advance for assisting us in this process. We have continued to be amazed by and appreciative of your support of the Fox Valley Family Medicine Residency Training Program. If you have any questions please do not hesitate to contact me.

Please fax this survey back to our Education Program office by Friday, September 22, 2006. The fax number is 920-832-2797

Yours in Resident Education,

Mark J. Thompson, MD
Program Director, UW Fox Valley Family Medicine Residency
Pager: 616-3732

UW Health Fox Valley Family Practice
920/832-2783

229 S. Morrison Street
FAX 920/832-2797

Appleton, WI 54911-5
http://www.fammed.wisc.

NO. 421 P. 1

Certification Regarding Residency Rotation to Non-Hospital Site

This form is to be filled out by each physician engaged in supervising residents at the location or by a person with personal knowledge of all the information furnished herein.

Physician Name: [redacted], MD
Name of Physician Practice/Employer: [redacted]
Address: 200 Theda Clark Medical Plaza, Neenah, WI 54956
Phone No.: 920-729-2510

Federal identification number: [redacted]

Specialty ***(circle one)*****:**

General/Family Practice	Internal Medicine
Surgery	Pediatrics
OB/GYN (circled)	Radiology
Psychiatry	Anesthesiology
Pathology	
Other (specify) ____________	

The University of Wisconsin Department of Family Medicine is gathering information necessary for compliance with Medicare requirements. Please read the following questions carefully and answer to the best of your knowledge. If you have questions, please call Theresa Rohm or Mark Thompson, MD at (920)997-8409.

1. **Which of the following best describes the manner in which you are compensated for your services in the practice where you are involved in supervising residents in the Department's programs?**

____ I am a solo practitioner and my earnings from my practice are based solely on my personal productivity for patient care services which I personally perform.

_X_ I practice within a group and am an owner of some or all of the practice where I work. My earnings from my practice are based solely on my personal productivity for patient care services which I personally perform.

____ I practice within a group as either an owner or as an employee, and my compensation is based on patient care revenue from services I personally perform as well as other factors which may include seniority, administrative duties, and capital investment.

R:\GME\06-07 academic year\AGREEMENTS\2006-09-14 Rotation Preceptor Certification (vB Revisions).DOC

2. How many hours do you spend ***in a non-hospital setting*** that fit within the categories set forth below, for each individual resident block rotation? (Use units of quarter hours if the number of hours for any category is less than one).

Specify hours per resident per week ***in a non-hospital setting:***

10 **Patient Present Teaching**—This category is for time spent teaching a resident in the *physical presence of the patient.*

10 **Patient-Related Teaching but Patient Is Not Physically Present**—This category is for time spent with a resident *discussing a specific patient* and which relates to the diagnosis and treatment of the patient but the patient is *not* physically present.

1 **Teaching Not Related to the Diagnosis or Treatment of an Individual Patient**—This category is for time spent with a resident teaching the resident but when a patient is not physically present and the teaching does not relate to the diagnosis or treatment of an individual patient.

0.25 **Resident Evaluation and Other Administrative Time**—This category is for time spent completing evaluation forms, coordinating with the program director, or which otherwise relates to having one or more residents rotate to your office or clinic but which does not fall into the preceding three categories.

Certification

The undersigned represents that he/she has personal knowledge of the information set forth above, and certifies that the information provided above is true and correct to the best of his or her knowledge. The undersigned also understands that the information provided herein will be relied on by a hospital in making claims to the Medicare program for support of residency programs in which the hospital participates, and may be provided to the Centers or Medicare and Medicaid Services, or its agents or contractors.

Signature

Name

10-4-06

Date

HealthCare

March 23, 2007

VIA OVERNIGHT DELIVERY

The Honorable 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: **CMS-1529-P**
Prospective Payment System for Long-Term Care Hospitals RY 2008
Proposed Expansion of the 25% Rule to Certain Situations Not Currently Covered Under Existing §412.534 and Other Policy Changes
Proposed Rule, 72 Fed. Reg. 4776 (Feb. 1, 2007)

Dear Ms. Norwalk:

This letter represents comments and recommendations from Triumph HealthCare regarding the above referenced proposed rule for long-term care hospitals (LTCHs) for the RY 2008. We have serious concerns and questions regarding these proposed regulations, which are outlined below.

25% Rule Expansion

The previous regulations put in place the 25% Patient Quota rule for Hospitals within a Hospital (HwHs). Although we disagreed with this rule for those that had followed the regulation on separateness, we understood it was to prevent co-located LTCHs from acting as step-down units of short term acute providers in which they were located. However, we have serious concerns about the extension of this 25% quota rule in the proposed regulation, as you are proposing to apply this quota to all LTCHs regardless of location. Patients and their families will clearly be those most negatively impacted by this proposed rule.

- By extending this rule to include freestanding LTCHs, CMS is severely restricting patients' choice and access to care in areas where LTCHs are integrated into the overall patient care system. In order to receive the same level of care that patients currently enjoy, they will be forced to go to different LTCHs in other areas, possibly far away from

7333 North Freeway, Suite 500 | Houston, TX 77076 | tel: 713.807.8686 | fax 713.807.8604 | www.triumph-healthcare.com

home and family members. This will not be what is best for the patient. In addition, this rule forces the physician to practice in a new setting, since it will not be economically feasible for the LTCH to accept patients at a payment rate which is considerably below the cost of providing care. Please provide an explanation as to how this regulation will not limit patient choice and access to care.

- According to CMS, RY 2005 MedPAR files indicate that 88% of freestanding LTCHs receive more than 25% of their Medicare discharges from an individual acute care hospital. Why is CMS proposing regulations that will have a significant impact on 88% of the LTCHs when data to support the justification for the rule (not paying "twice") is "poorly understood?" Further, your own impact estimates suggest a reduction of 1.9%. How is this possible if 88% of LTCHs would be negatively impacted?

- CMS has obviously exceeded its authority to regulate unrelated freestanding hospitals. There is no broad authority for the Secretary to use the HWH regulations and expand it to a restriction on admissions, via payment reductions, to LTCHs that have no relationship to the referring STACHs.

- There is no evidence that LTCHs are causing CMS to pay twice for the same episode of care. Many LTCH patients have exacerbated conditions, new procedures, or other complications that cause them to be appropriate for the extended stays that acute patients require and LTCHs provide. RTI itself said that the evidence on paying twice on this issue is unclear. Yet you propose a regulation in this vacuum.

- Patients in rural areas or one hospital towns will have no access to nearby LTCHs as LTCHs cannot survive in towns where hospitals exceed 50% of the market but the cap is at 50%. There is no second 50% for the LTCH to get patients from. Therefore payments will be severely restricted for virtually all patients or else patients will have to travel long distances.

- LTCHs have no data by which to determine what patients are outliers from unrelated independent STACHs, limiting their ability to care for patients that even CMS thinks should be in LTCHs.

- The most acutely ill patients are typically concentrated in a few leading hospitals in cities. This 25% expansion would directly contradict the understandable desire of CMS to see LTCHs take only the most severely ill. If the severely ill are concentrated in one STACH and you exceed 25% admitted from that STACH the LTCH would be severely penalized.

- The regulation is not specific in its definition of the referring STACH entities that the 25% cap applies to (STACH campus, facility or provider). On the LTCH side, what is the entity measured in the application of the 25% cap (LTCH Campus, facility, or provider)? A provider number definition on the LTCH side would be simpler to track and control, and would be less subject to manipulation.

- Policies on inappropriate, or early discharges, or incomplete episodes of care should be addressed to the STACH not LTCHs. The transfer rules, re-admission rules, and DRG rules for STACHs should be used to minimize the issue, not penalize LTCHs. As we showed in our response to last years rule, our patients had long lengths of stay in STACH and have already completed their original episode of care in the STACH.

As an alternative to those inappropriate regulations, we propose:

- Endorsing the bills currently in congress that would ensure appropriate admission of high acuity patients and ensuring the majority of patients in LTCHs are appropriate.

- Working with the industry on these bills to improve them as opposed to your current lobbying against these bills.

If you must implement these regulations which we strongly oppose, we ask that you:

- Provide a phase in period as you did with HWH which you felt was a much more abusive system.

- Raise the 25% or other appropriate percentage for freestanding. Perhaps 50% for urban and capping at 75% for rural or market dominant. This would eliminate the most abusive hospitals as you see them.

- Clarify the language of the regulation using provider number as the defined 25% for LTCHs to make it simpler to implement and less subject to manipulation of satellites and campuses.

- Include the elimination of the grandfathering of older facilities so all freestanding LTCHs are on a level playing field, or

- Grandfather all existing LTCHs at 50% and apply the 25% to all new LTCHs after July 1, 2007.

- Implement a methodology so LTCHs can determine outlier status for incoming STACH patients.

Short Stay Outlier (SSO) Proposal

- This expansion of last years SSO Policy is premature as the effect of last years policy isn't definitively known but our data show is having a serious negative impact.

- Certain LTCH DRG's such as 476, 541, and 542 have extremely long geometric mean lengths of stay, much longer than 25 days. For these DRG's, even though their length of stay could be much greater than 25 days, they would still be paid under the short stay methodology and therefore be subject to severe payment reductions. These are medically

complex cases for which the payment under the proposed rule would not come close to reflecting the cost of caring for these patients. Last year, you excluded patients with lengths of stay greater than 25 days from the short term acute blend.

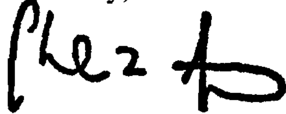
- STACH rates have nothing to do with these patients and shouldn't be applied to them. The only thing these patients share with STACH patients is a DRG number: different patient, different age, different condition, different episode of care, different co-morbidities, and different acuity.

If you must implement this ill-timed and inappropriate policy:

- Exclude SSO's that exceed 25 day LOS.

In closing, CMS should work with the industry to limit excesses by a few, not punish the many. Clinical criteria and limitations on STACH transfers at the STACH are a fair way of ensuring that LTACs treat only appropriate patients. CMS should understand that LTCH growth has already essentially stopped due to prior years' regulations and margins have fallen precipitously. CMS should do further study and follow the recommendations of RTI and MedPAC. If you must implement these excessive regs, use caution and a phase-in period with reasonable restrictions.

Sincerely,



Charles L. Allen
President/Chief Executive Officer

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BAY
REGIONAL MEDICAL CENTER
A McLAREN HEALTH SERVICE

March 21, 2007

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

RE: Medicare Program, 2008 Proposed Update Rule
72 Federal Register 4776 *et seq.*

Dear Ms. Norwalk:

I am the Chief Financial Officer of Bay Special Care Hospital and Bay Regional Medical Center. I would like to share my thoughts on the 2008 Proposed Update Rule.

Bay Special Care Hospital is a 31-bed long-term acute care hospital in Bay City, Michigan, and since its inception, has been the premier provider of long-term acute care hospital services. In our geographic locality, there is only one acute care hospital that provides 95% of admissions to Bay Special Care Hospital. If the proposed 25% cap of admissions from a single source facility is implemented, we will be unable to fulfill our mission of providing care to this patient population. We must find other ways to save healthcare dollars.

I would respectfully ask that you not support the current language in the rule, and:

- **Request that the CMS not expand the 25% rule to freestanding and grandfathered hospital and reject the extreme SSO policy currently under consideration.**
- I support the six-month extension for comments to allow the national trade organizations to collaborate for the good of the industry.
- I support a LTAC moratorium until 2010, as substantiated in the study of the Lewin Group.
- I support the development of a universal admission, continued stay and discharge criteria for LTACs, based on a validated study
- I support continued QIO review and oversight of the LTAC industry.

As a proud employee of Bay Special Care Hospital/Bay Regional Medical Center, and a concerned citizen, I respectfully request that you take these comments into consideration prior to the final ruling. Thank you.

Sincerely,

Brian Kay
Chief Financial Officer

1900 Columbus Avenue • Bay City, Michigan 48708
Phone: (989) 894-3000
www.baymed.org

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March 20, 2007

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

RE: Medicare Program, 2008 Proposed Update Rule
72 Federal Register 4776 *et seq*

Dear Ms. Norwalk:

My name is Kurt Miller, and I am employed by Bay Regional Medical Center in Bay City, Michigan. I am writing on behalf of Bay Special Care Hospital, 3250 E. Midland Road, Bay City, Michigan 48706, in reference to proposed rule changes that would affect allowable admissions to specialty care hospitals.

Bay Special Care Hospital (BSCH) was established 1994. Since its inception, BSCH has been the premier provider of long term acute care hospital services within our geographic area. This 31-bed hospital provides direct, long-term acute care services for approximately 300 patients annually, focusing on the complex medically compromised patients within our community. Approximately 48% of BSCH patients are discharged home — a remarkable statistic, given the age and medical complexity of these patients. If the proposed changes to the current legislation are implemented, it will seriously compromise the hospital's ability to care for these patients within Bay County. In our geographic locality, there is only one acute care hospital (BSCH), which does provide more than the proposed 25% cap of admissions from a single source facility. If this legislation is implemented, BSCH will be unable to fulfill its mission of providing care to this patient population.

In my current role as Director of Marketing and Public Relations for Bay Regional Medical Center, I hold primary responsibility for communicating the depth and breadth of our services to East Michigan. I do not relish explaining to our constituents why a transfer to BSCH from Bay Regional Medical Center cannot be accomplished because of this rule change. Patients and their families will be seriously affected due to increases in travel time, and a potential lack of continuity in their care.

In addition to the deleterious effect on patient management, the potential economic impact on BSCH employees and the community would be substantial. Employees potentially would lose their jobs, which would have an immediate impact on an already struggling local economy.

I would respectfully ask that you not support the current language in the rule, and:

- Request that the CMS not expand the 25% rule to freestanding and grandfathered hospitals and reject the extreme SSO policy currently under consideration.

1900 Columbus Avenue • Bay City, Michigan 48708
Phone: (989) 894-3000
www.baymed.org

- I support the six-month extension for comments to allow the national trade organizations to collaborate for the good of the industry.
- I support a LTAC moratorium until 2010, as substantiated in the study of the Lewin Group.
- I support the development of a universal admission, continued stay and discharge criteria for LTACs, based on a validated study
- I support continued QIO review and oversight of the LTAC industry.

As a proud employee within in the local health care community, I respectfully request that you take these comments into consideration prior to the final ruling.

Respectfully,

Kurt B. Miller – Director
Marketing and Public Relations

HEALTHSOUTH

March 23, 2007

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, Maryland 21244-1850

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008; Proposed Annual Payment Rate Update, and Policy Changes; Proposed Rule, 72 Fed. Reg. 4776 (February 1, 2007)

Dear Ms. Norwalk:

On behalf of HealthSouth Corporation, please accept the following comments regarding the Notice of Proposed Rulemaking (NPRM) for Rate Year 2008 for Long-Term Acute Care Hospitals (LTCH), which was published by the Centers for Medicare and Medicaid Services (CMS) on February 1, 2007.

As of December 31, 2006, HealthSouth owned and operated 10 LTCHs in the states of Texas, New Jersey, Pennsylvania, Nevada, Florida, Indiana and Louisiana.

We strongly support the comments which have been submitted under separate cover by the Acute Long Term Hospital Association (ALTHA), of which we are a member. This letter provides detailed comments and recommendations regarding the NPRM. While we generally support all of the ALTHA comments, we would like to draw your particular attention to the following key points:

Expansion of the "25% Rule" to Freestanding LTCHs. We strongly disagree with the proposed expansion of the Hospital-within-Hospital (HIH) 25 percent case limitation to each referring Short-Term Acute Care Hospital (STACH). Any arbitrary cap on beneficiary referrals not tied to medical need will have a negative effect on patient outcomes by constraining the ability of physicians to place patients in the most appropriate care setting.

HealthSouth and the LTCH industry continue to support the implementation of patient and facility level patient criteria to better define the medical conditions required for admission to a LTCH. We cannot support a policy direction that seeks to address LTCH growth through payment reduction policies or restrictions on access that are not

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http://www.healthsouth.com

tied to medical evidence. We believe that the LTCH sector and CMS can, and should, work together to develop other, more patient-focused alternatives.

This proposed rule fails to cite data to support the assertion that all or most freestanding LTCHs are functioning as "units" of STACHs and that Medicare is paying twice for the same episodes of care. The proposed policy will limit LTCH referral to 25 percent in urban areas and 50 percent in rural areas. In order for a LTCH to maintain compliance with this proposed policy, relationships with no less than four (4) referring STACHs that treat complex medical cases would be required in urban setting and no less than two (2) in the rural underserved areas. The proposed rule presents no data to assess the effect of these requirements on access to care. Our own experience indicates that this policy would in effect eliminate LTCH services in many markets of the country if implemented at these levels.

CMS has made multiple changes to the LTCH Prospective Payment System (PPS) over the past few years. These policies included a change in the short-stay outlier policy (SSO), the 5 percent readmission policy, 3-day or less interrupted stay policy, the HIH 25% policy, relative weight refinements, and the STACH post-acute transfer/discharge policy. The overall LTCH payment system is just now completing its full phase-in. We believe that the effects of all of these changes need to be reviewed and consider in the context of a thorough data analysis prior to the expansion of this policy to freestanding LTCHs. As ALTHA has demonstrated in their comment letter, the growth in the number of LTCHs has all but stopped based on CMS' own data. We believe that CMS should allow all of these policies to become fully implemented and collect post-implementation data prior to making further significant policy changes.

The NPRM has estimated that the impact of this proposed policy would be a reduction of 2.2 percent in RY 2008. While no support is provided for our analysis, it is clear that the proposed rule does not acknowledge the RY 2009 impact. Our estimates indicate that the fully phased-in effect of this policy is well in excess of a 10 percent reduction in Medicare payments to providers. CMS has indicated that hospitals could avoid these impacts by not exceeding the cap of 25 percent. However, the NPRM fails to recognize that certain fixed costs of operating a LTCH can not be eliminated. As a result, a number of LTCHs will face the potential for reimbursement falling below the cost of care.

For these reasons, we believe that this policy should not be implemented as proposed. We believe that CMS should wait to analyze more current data after all existing policies have been fully implemented prior to making significant additional changes to the LTCH PPS. However, if CMS finalizes this policy in spite of the industry concerns, consistent with the ALTHA recommendations, we recommend that the referral limitation be set at the applicable percentage for all freestanding LTCHs at 50 percent in light of the lesser policy concerns CMS has with these hospitals compared to HIHs and satellites and provide for a longer phase-in period – at least as long as the phase-in period for HIHs and satellites (4 years). CMS should also not revoke the grandfather status for HIHs currently afforded grandfather status.

Short Stay Outlier Payment Policy Proposal. CMS significantly changed the SSO payment policy in the RY 2007 final rule.[1] Given the scope of this change, it would be prudent to evaluate its effects prior to amending the payment methodology again. We believe that these policy changes are creating a significant payment cliff between the SSO payment and the full LTCH DRG payment thus undermining the integrity of the LTCH PPS design. We are concerned about the continued merging of the STACH payment system with the LTCH payment system is causing most if not all SSO cases to be paid below the cost of the case. We believe that the payment system must maintain its integrity and continue to pay providers at no less than the cost of the case. As indicated above, we believe that controlling the types of cases being treated in the LTCH setting is best achieved through the adoption of patient and facility level patient criteria to better define the medical conditions required for admission to a LTCH and not through payment reduction policies. Lastly, the proposed policy fails to acknowledge the impact of patients that expired during a SSO stay. Treating cases at the STACH payment levels and average length of stay fails to properly recognize the complexity of the cases being treated in this setting.

For these reasons, we recommend against the implementation of any further changes to the SSO payment policy until more current data is analyzed and shared with the LTCH industry.

Market Basket Increase and Coding Adjustment. We concur with ALTHA that a full market basket update should be provided for in the RY 2008 final rule. The most recent MedPAC margin analysis, projects LTCH margins to be close to zero before taking into account the additional cost reductions. A market basket update is necessary to permit LTCHs to continue to make investments in personnel and equipment required to sustain a high quality of patient care.

The NPRM proposes a coding adjustment of 2.49 percent for an apparent increase in the case mix index due to coding improvements that CMS believes not to be related to changes in the severity of LTCH cases. This reduction is predicated on an STACH study that was done some 20 years ago. The proposed rule adopts the lowest value for real case mix change of 1.0 percent over the higher end of the range of 1.4 percent. This data does not adequately address the full complexity of cases treated in the LTCH setting. Until more credible data can be presented to justify this change, we believe that no coding adjustment should be implemented.

One-Time Adjustment. Given the MedPAC margin analysis and the many other policies changes implemented to date, we believe that there is no longer a need to make a One-Time adjustment.

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[1] 71 Fed. Reg. 27798-27939 (May 12, 2006).

Budget Neutrality in Re-weighting of LTC-DRGs. The NPRM proposes to make annual updates to the recalibration of the LTC-DRG relative weights in budget neutral fashion. We support this proposal.

We thank you for the opportunity to comment on this proposed rule and look forward to working with CMS to make further improvements in the LTCH PPS.

Sincerely,

Rob Wisner
Senior Vice President, Reimbursement

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MAR 26 2007

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 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.

680 South Fourth Avenue Louisville, Kentucky 40202
502.596.7300 www.kindredhealthcare.com

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.

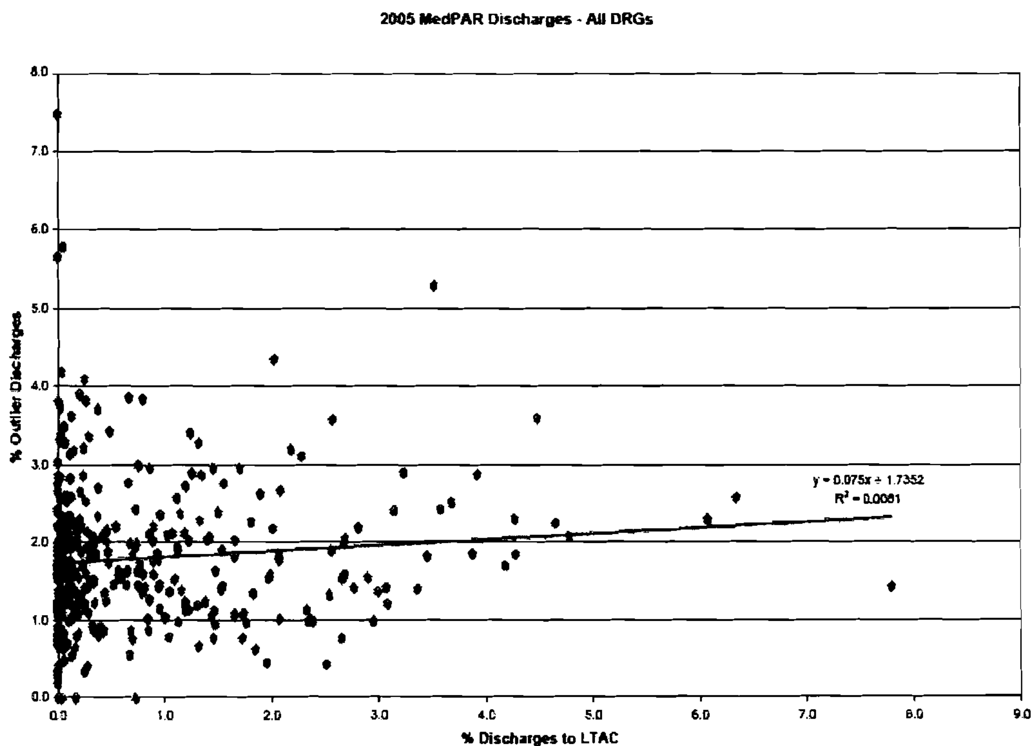
The following charts show the relationship between the percentage of high cost outliers in acute care hospitals and the percentage of total discharges to LTACHs in each of 385 metropolitan areas and metropolitan divisions. Using the appropriate field in MedPAR, the y-axis identifies acute hospital high 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:

<u>All DRGs</u> (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



<u>Top 10, 20, 30 and 50 Frequency DRGs</u> (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.

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Figure 2

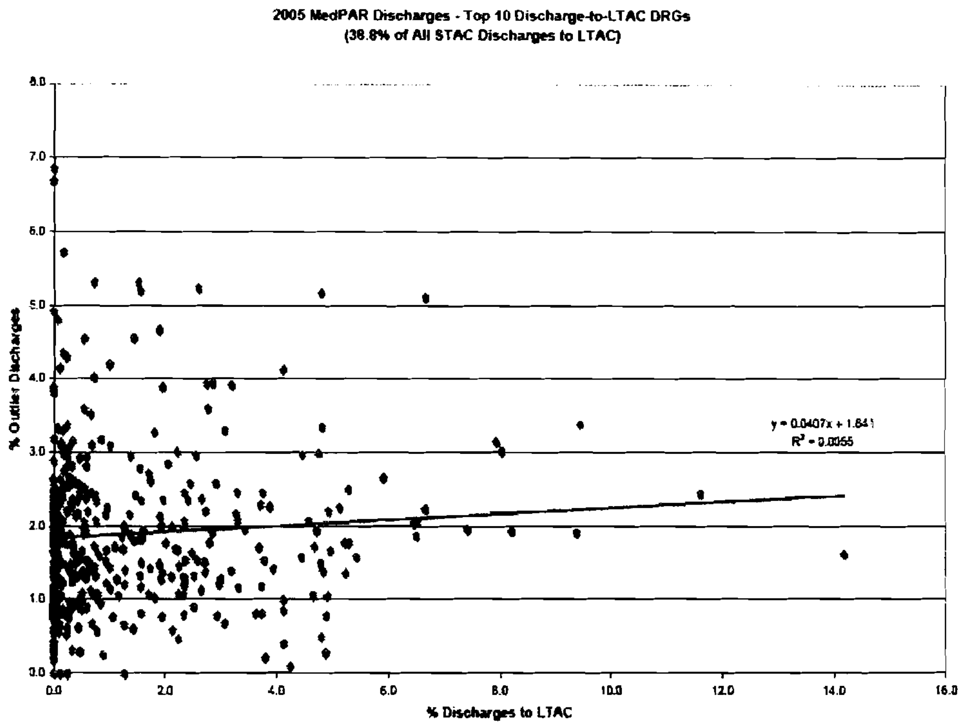

Figure 3

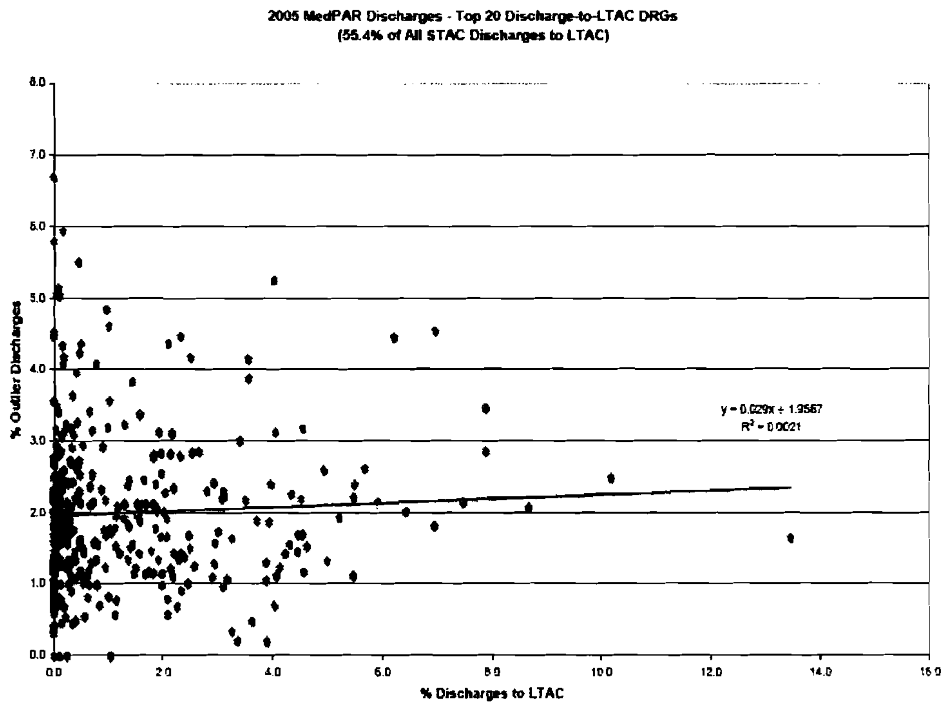

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Figure 4

2005 MedPAR Discharges - Top 30 Discharge-to-LTAC DRGs
(65.8% of All STAC Discharges to LTAC)

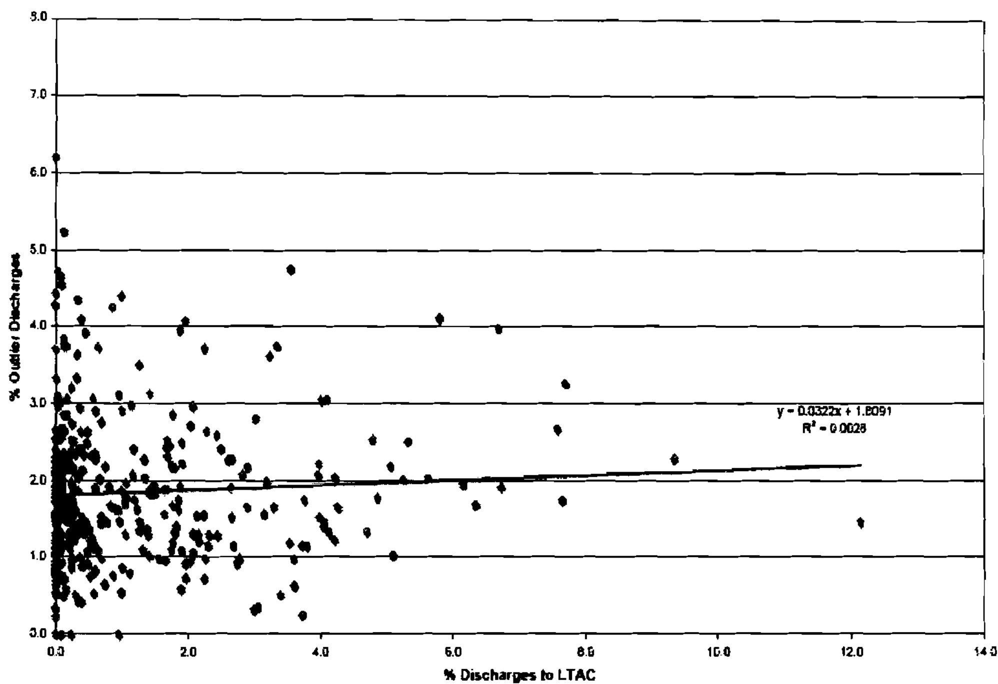
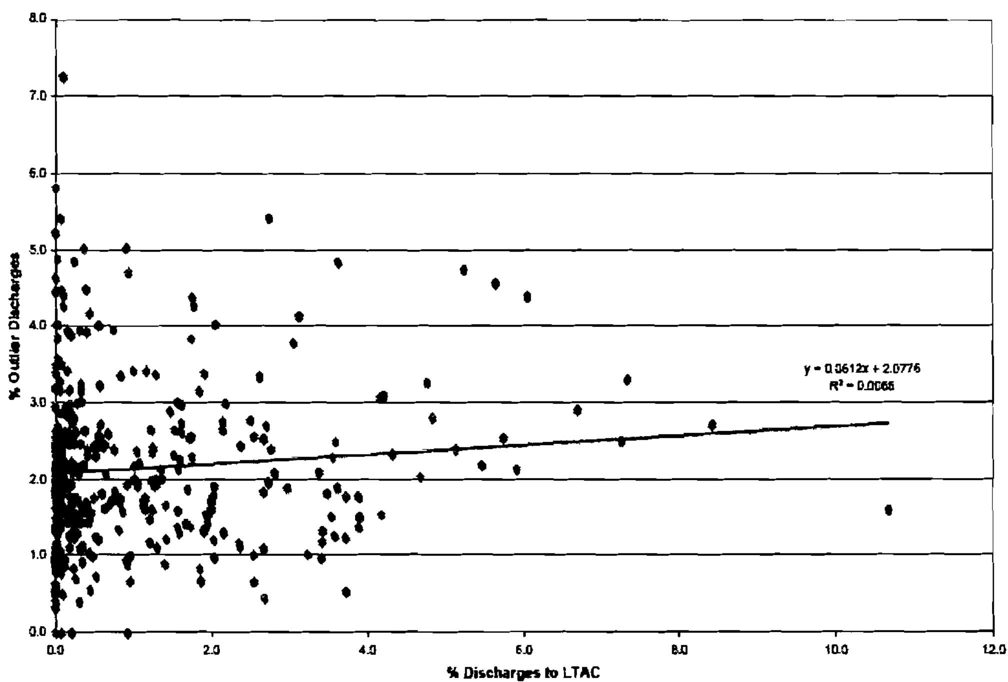


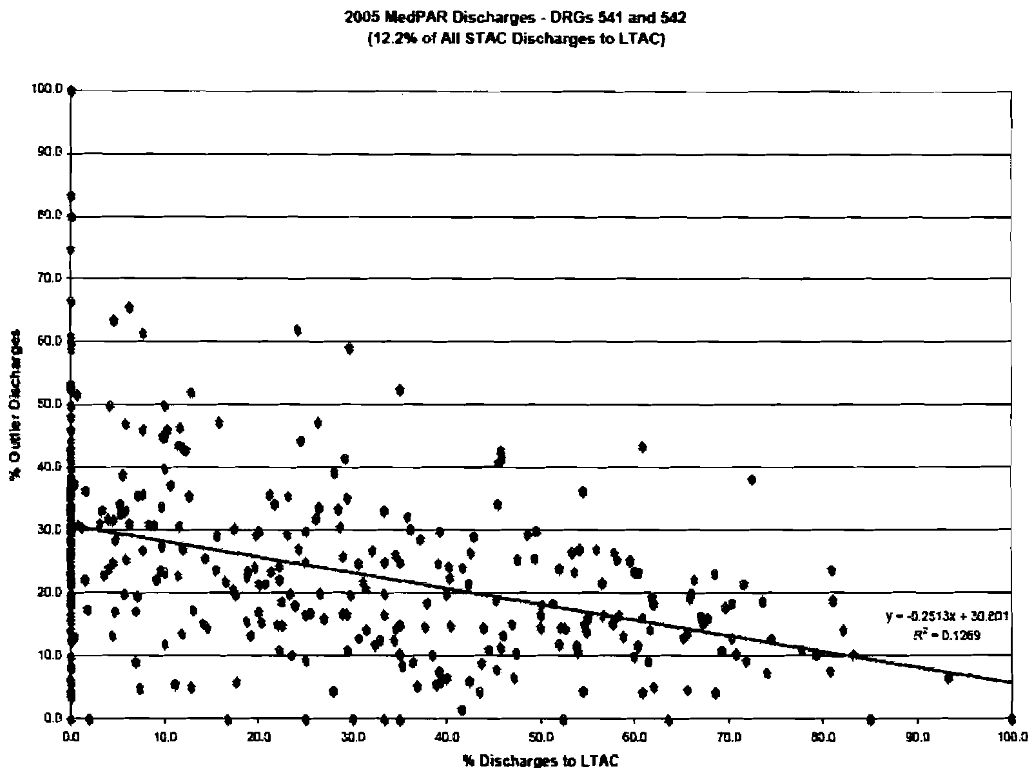
Figure 5

2005 MedPAR Discharges - Top 50 Discharge-to-LTAC DRGs
(76.8% of All STAC Discharges to LTAC)



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



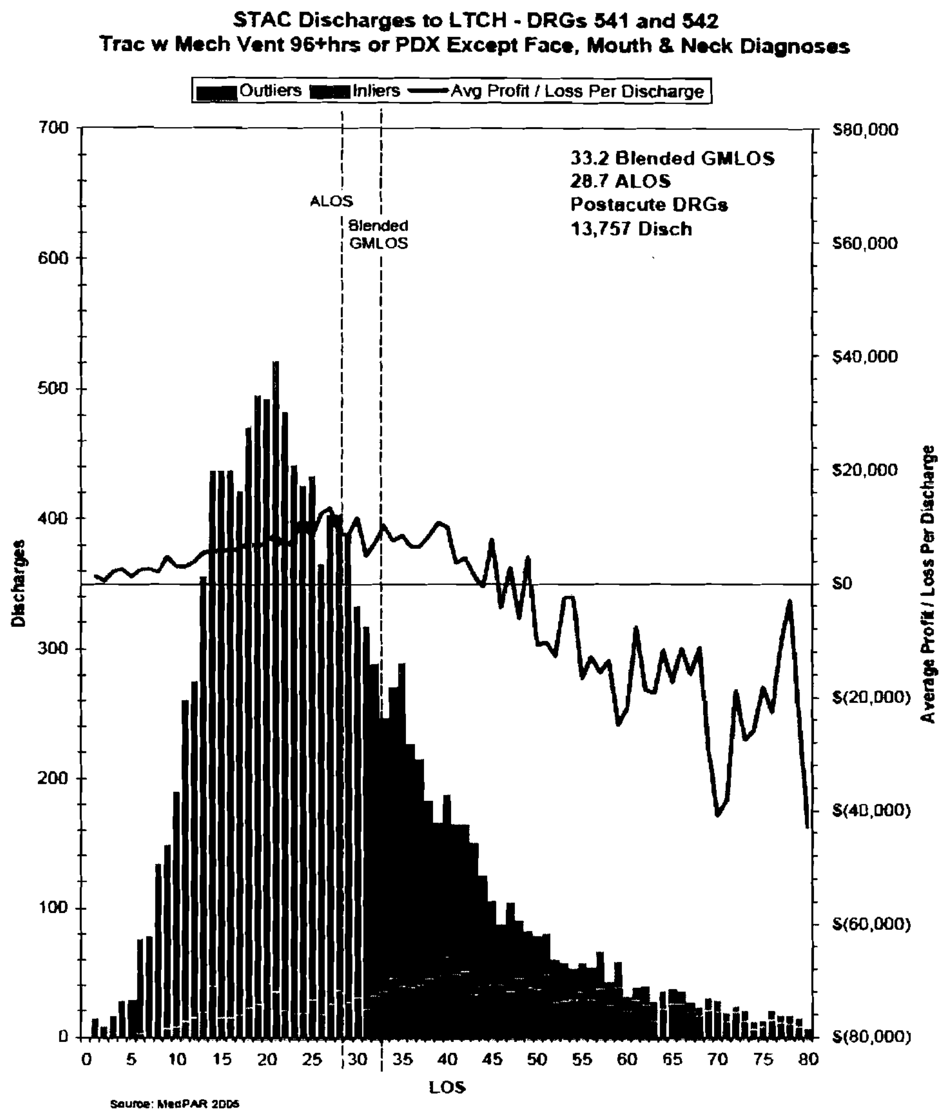
Despite the correlation indicated by the chart, this pattern does not support CMS's concern that LTACH utilization unduly increases costs to the Medicare program, for three reasons:

- 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.

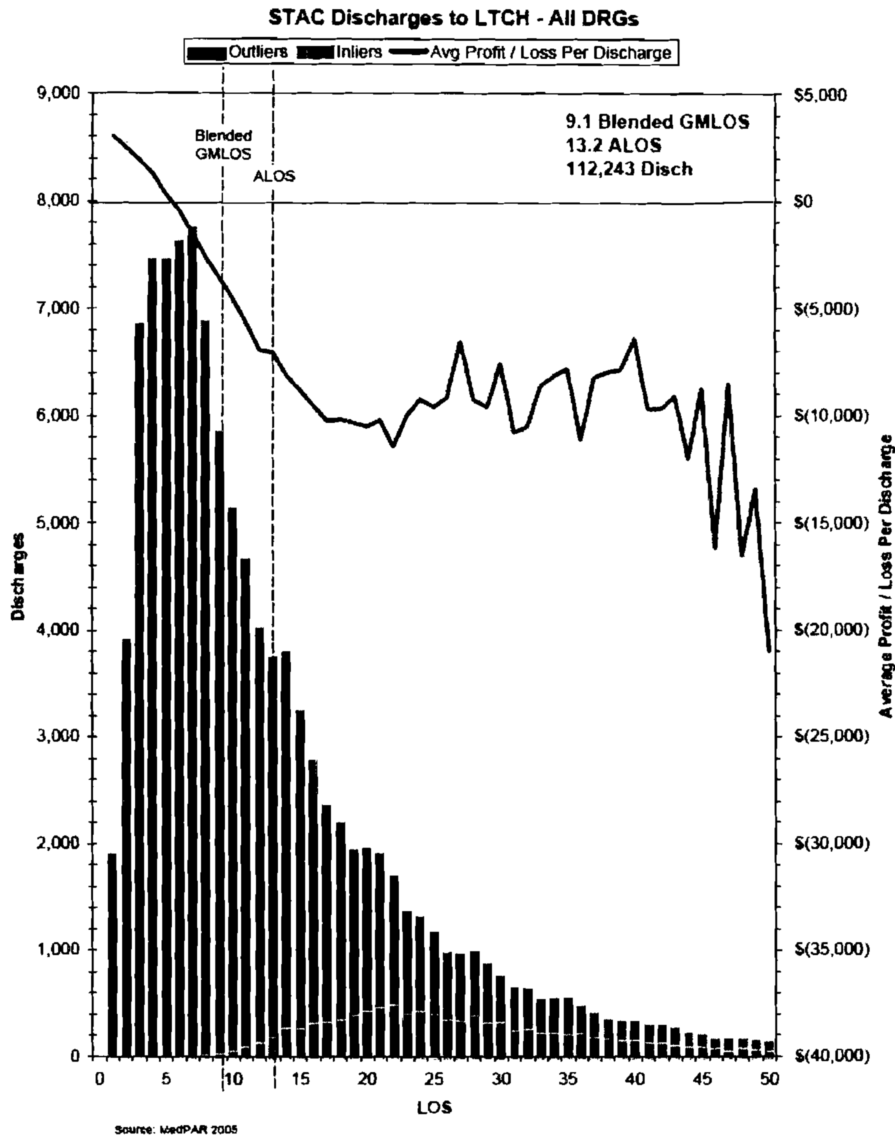
Figure 7



- 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.

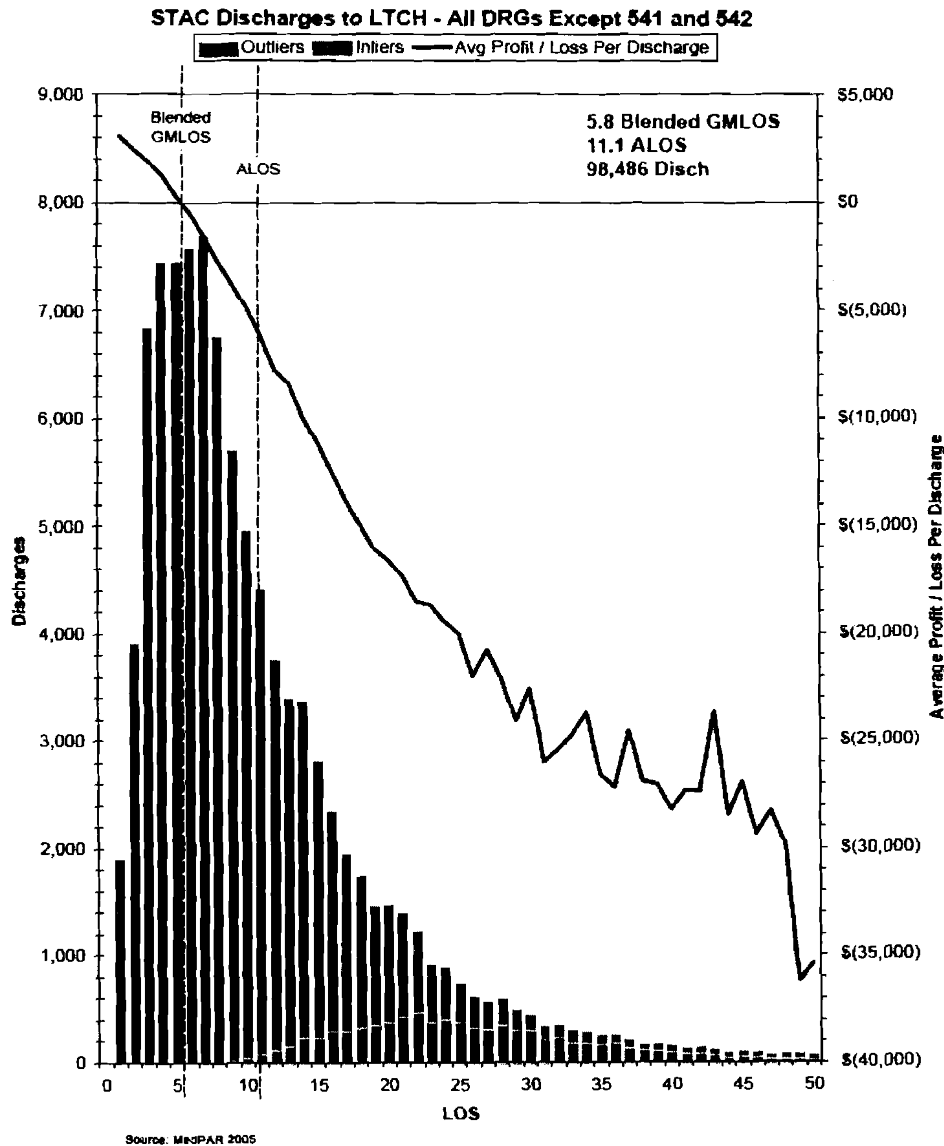
The graph in Figure 8 shows that the ALOS for acute hospital patients eventually sent to LTACHs is more than 4 days longer than the geometric mean length of stay for patients in the same DRGs.

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

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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

LTACH Rank	DRG	DRG Description	LTACH PPS Discharges	IPPS Discharges	IPPS Discharge to LTACH Rank
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").

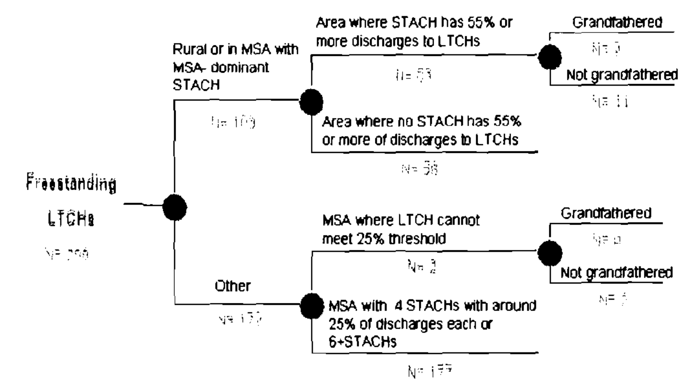
c. The Proposed Rule Will Result in a Number of Unintended Consequences that Weigh Against Its Implementation.

(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 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")[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.

[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

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%

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

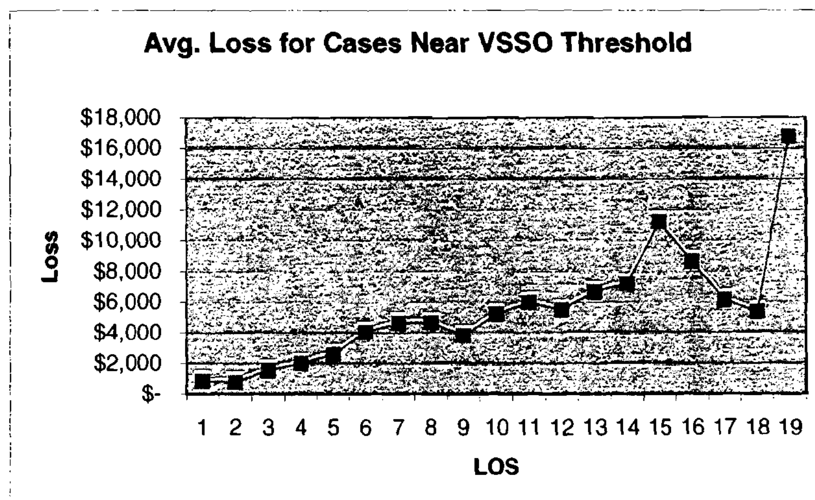
48.4 days in the LTACH would fall into this category. There are 13 DRGs according to CMS's table in the proposed regulation in which the IPPS comparable threshold is longer than the short-stay outlier threshold (5/6th the GMLOS), meaning that patients with LOS longer than the short-stay outlier threshold 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.

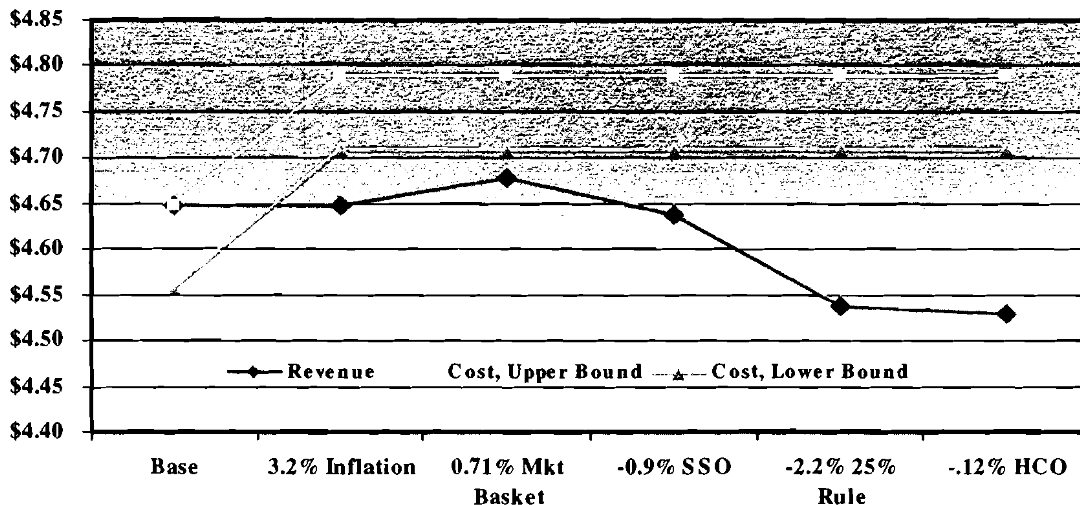
[7] We acknowledge that MedPAC recommended a zero market basket update recommendation for LTACHs for RY 2008 but make the following points. First, MedPAC's recommendation did not contemplate the payment changes proposed by CMS that would bring LTACH payments well below costs. Second, we disagree with 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

RY 2008	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 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.

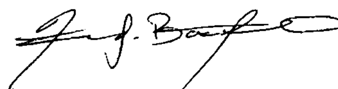
3. Kindred Position and Alternatives

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

AMERICAN OSTEOPATHIC ASSOCIATION

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March 26, 2007

MAR 26 2007

The Honorable Leslie V. Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1529-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

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-1529-P)

Payment for Direct Medical Education

Dear Administrator Norwalk:

On behalf of the nation's 59,000 osteopathic physicians and more than 12,000 osteopathic medical students, the AOA is pleased to take this opportunity to comment on proposed changes to Medicare policies on training residents in nonhospital settings. We very much appreciate the time CMS staff has spent meeting with us, listening to our members' concerns and trying to address them in a manner that reduces confusion and administrative burdens. Although the proposal does not resolve the underlying problem, it is a significant first step toward greater clarity, flexibility and predictability in an area that has caused significant difficulty for teaching hospitals over the last five years. The AOA is committed to working with the agency and Congress to bring this matter to a final resolution. In the interim, we believe that the modifications we suggest would improve the proposal, better adapting it to the way osteopathic interns and residents are trained. We respectfully request that CMS incorporate these recommendations in the final rule as it affects Medicare graduate medical education (GME) policies.

Training Residents in Nonhospital Settings

The Medicare statute allows a teaching hospital to count the time residents spend in nonhospital settings if the residents are engaged in patient care activities and the hospital incurs "all or substantially all" of the costs of training in that setting. This provision was a Congressional response

to longstanding concerns that Medicare payment policy created disincentives for training interns and residents in the full range of settings where physicians provide patient care. It also responded to the needs of primary care residents for whom training in nonhospital settings is particularly important. More than 65 percent of AOA-accredited residencies are in family practice, internal medicine, obstetrics and gynecology or pediatrics. Training in nonhospital settings is not limited to primary care specialties, however. Ambulatory training also is important in surgery, cardiology, gastroenterology, and other specialty and subspecialty areas. Osteopathic medicine has a proud tradition of training both primary and nonprimary care physicians, many of whom practice in rural or underserved communities.

Beginning in 1999, the Centers for Medicare and Medicaid Services (CMS) changed its interpretation of "all or substantially all" of the costs of training to include supervisory faculty costs as well as resident salaries and benefits. In 2002, the fiscal intermediaries began relying on this interpretation to deny the time residents spend in nonhospital settings if supervising physicians train residents on a voluntary, unpaid basis. Recently, the agency has extended that interpretation further, using it to challenge payment adequacy.

The AOA firmly believes that teaching hospitals and nonhospital sites are in the best position to determine whether there are supervisory training costs in nonhospital settings, and, if so, how they should be compensated. Because residents train in ambulatory settings to gain clinical experience, we believe that those costs are de minimus. Physicians who volunteer their time to train residents in offices, clinics and other ambulatory settings should be allowed to do so without regulatory requirements that impose supervisory costs despite the intentions of the parties. Group practices that collectively decide to volunteer the time their physicians spend training residents should be allowed to do so. Where physicians are paid based on predetermined compensation arrangements, hospitals and nonhospital settings should be allowed to document that no part of the compensation is based on training residents. If that is the case, there are no supervisory teaching costs incurred by the practice.

Although our views on nonhospital training are unchanged, we believe that the current regulatory environment creates untenable burdens and risks for our members. Section XII of the rule proposes an alternative methodology for determining how much a hospital must pay in order to count residents training in ambulatory settings. With the modifications we recommend, that methodology could provide a measure of relief for teaching hospitals until the underlying issues can be resolved.

The Proposed Rule

If finalized, the proposed rule would establish several proxies hospitals could use to determine when and how much must be paid to nonhospital settings in order to satisfy CMS' interpretation of the Congressional mandate. In accordance with the proposal, physician compensation could be calculated using some or all of these proxies instead of relying on current requirements, which call for 100 percent payment of an amount based on physician-specific time and salary information. Because that information often is unavailable, use of *appropriate* proxies could benefit teaching hospitals substantially. Current requirements for computing costs would remain in place for those that wish to document actual salary and effort on a physician-specific basis.

In accordance with the proposed rule, a hospital could calculate the amount it must pay to a non-hospital setting using the following formula:

> 0.90 x [(sum of each FTE resident's salary and benefits (including travel and lodging if applicable)) plus the portion of teaching physician compensation attributable to direct GME activities].

In this formula, the portion of teaching physician compensation attributable to direct GME activities would be calculated as follows:

> (3/number of hours the nonhospital site is open per week) x (the national average salary for each teaching physician at the site, by specialty.)

In this formula, "3" is a proxy representing CMS' estimate of the number of hours per week a supervisory physician spends per resident on nonpatient care GME activities such as conferences, practice management, lectures, evaluations and other administrative activities.

The formula is intended to capture training costs in the nonhospital setting, including the time physicians spend in "direct GME activities" that do not involve patient care. Each of the components of the formula is discussed below.

Ninety Percent Payment Threshold

According to the proposed rule, the statutory mandate would be satisfied if a hospital paid at least 90% of the total expenses of the training program at the nonhospital site. If this 90% threshold is met by paying residents' salaries and benefits (plus travel and lodging if applicable), the hospital would not be required to pay anything additional for physician compensation. Assuming a 1:1 physician/resident ratio, it seems unlikely that this would be the case because physician compensation is substantially greater than resident salaries and benefits, particularly when the physician is a nonprimary care specialist or subspecialist. If resident salaries and benefits (plus travel and lodging) are less than 90% of the total training costs, the hospital would be required to pay the setting the amount necessary to reach the 90% level.

Currently, CMS requires hospitals to pay 100% of the nonhospital costs based on actual physician salary and effort. Consequently, the proposed change better embodies Congressional intent and gives full effect to <u>all</u> of the words of the statute. The AOA appreciates this change but believes that the proposed threshold still is too high. We recommend that the threshold be changed to require payment of 75% of the nonhospital costs, calculated in accordance with the formula or current agency requirements.

Prior interpretations of the phrase "all or substantially all" support our recommendation. Indeed, CMS itself has defined "substantially all" as 75% in regulations on financial relationships between physicians and entities that furnish designated health services. Regarding the provision of services by physicians who are members of a group practice, CMS requires that "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 CFR §411.352(d) (emphasis supplied.) This provision interprets the Stark law, which requires that each physician member of a group practice must furnish "substantially the full range of services which the physician routinely provides" on an individual basis. It also mandates that the practice is an association "for which substantially all of the services" of group member physicians are furnished though the group "and are billed in the name of the group." 42 USC §1395nn(h)(4)(A), (B). Although CMS initially proposed defining "substantial" as 85% in this context, it later lowered the threshold for "substantially all" to 75%, where it remains currently. 42 CFR §411.352(d); 60 *Fed. Reg.* 41914, 41931 (Aug. 14, 1995); 66 *Fed. Reg.* 856, 904 (Jan. 4. 2001.)

Accepted rules of statutory interpretation also support the AOA's recommendation. According to these rules, the same term should be defined in the same way within the ambit of a single statute. CMS already has defined the words "substantially all" as 75% in interpreting Social Security Act requirements regarding the Stark provisions and physician practices. There is no compelling reason for CMS to decide that the same term means 90% when it interprets the phrase "all or substantially all of the costs of the training program in the nonhospital setting" in the same statute.

As now, the nonhospital provisions makes discretionary payment of physicians who are solo practitioners or those in group practices where compensation depends solely on each physician's own patient care billings. Conversely, payment would be required for group practices that compensate physicians based on a predetermined amount that is not attributable to the physicians' own billings if the amount paid does not reach the threshold level. According to CMS, in such cases, the agency assumes that the predetermined amount compensates the physician for all activities at the site, including supervising residents. This may be an erroneous assumption. Where a practice specifically states that compensation does not include training residents, the physician should be regarded as if he or she were in solo practice or paid based solely on patient billings.

Moreover, group practices are legal entities capable of determining the costs of the services they provide. There is no compelling legal reason why a practice cannot volunteer the time its members spend training residents or determine that there are no supervisory costs. Where a practice has made that determination and documents it in an agreement with the hospital, physicians in the practice should be treated as solo practitioners or physicians who are paid based on their own patient care billings.

Documentation requirements for using actual salary and effort information never have been clear. We recommend that CMS clarify these requirements in the final rule. When finalized, the rule also should clarify whether malpractice insurance may be included as a resident benefit when nonhospital payment is calculated.

Three Hour Proxy

Current Medicare policies require teaching hospitals to calculate physician supervisory costs based on actual time spent on "nonpatient care GME activities" and physician-specific salary information. These policies have created a number of problems. Salary information often is difficult to obtain because physicians and practices are reluctant to share compensation arrangements with third parties. Time estimates vary widely because the distinction between "patient care" and "nonpatient

care" activities is subtle and subjective. Basing payment for medical education on patient care revenues is inequitable and inappropriate.

As an alternative, the rule proposes a formula-based approach that uses proxies for determining physician time and compensation costs. The AOA appreciates this proposal but believes that the proposed 3 hour proxy is too high to reflect the time physicians spend on nonpatient care GME on a per week, per resident basis. Residents train in nonhospital settings to gain clinical experience that they cannot get in the hospital. Consequently, most of the time supervisory physicians spend in GME activity is tied directly to patient care. The proposed proxy fails to take this into account. Consequently, it is unrealistic and of limited utility.

CMS purports to base the 3 hour proxy on data provided by the AOA, the Academic Family Medicine Advocacy Alliance (AFMAA), and the Association of American Medical Colleges (AAMC). Indeed, at CMS' request, a brief, informal survey was conducted by the AOA and the AFMAA for the agency in 2005. The survey was developed and administered quickly in response to a timeline established by the agency. The AAMC did not administer the survey though representatives of the organization attended a meeting where survey results were submitted to the agency. These results indicate that there were a number of problems with the survey, including the indirect method of administration, poor response rates, and inconsistent responses. Given these problems, the AOA does not believe that the resulting data are a reasonable basis for the 3 hour proxy.

For example, the AOA does not maintain a roster of physicians who supervise osteopathic interns and residents in nonhospital settings. Training arrangements are established by individual teaching hospitals, which maintain contact information for the physicians who train their residents. Without a direct link to the physicians, the only option open to the AOA was to contact the directors of medical education (DMEs) of osteopathic programs and ask them to forward a survey instrument to their supervisory physicians. Because of the timing of the agency's request, the survey had to be sent to the DMEs in July, the busiest time of the graduate medical education year. Given the timing, the survey was administered electronically to reduce burdens on both the DMEs and the nonhospital physicians. At no point did the AOA have direct contact with these physicians nor was there any way to identify or follow up with survey respondents to verify incomplete or inconsistent answers.

The response rate to the AOA survey was very low. The survey instrument was sent to more than 250 DMEs. The number of supervisory physicians who received the survey from the DMEs is unknown. Only 39 individuals returned survey responses. Individual answers in many of these responses clearly indicated that the respondent was hospital-based, did not supervise residents in nonhospital settings, spent 0 hours per week in patient care, or otherwise was not an intended survey recipient. Two responses had to be excluded entirely because of inconsistent information. The remaining 37 respondents indicated that they spent a median time of 1.0 hour per week (mean of 1.1 hours per week) in teaching activities or resident instruction not related to patient care. Respondents reported spending a range of 0 to 5 hours per week in such activities. Given these responses, it is clear that 3 hours is too high to function as a realistic proxy. The AOA believes that an accurate estimate of physician effort is closer to 1 hour.

Because the data available to CMS are an inadequate basis for establishing the proposed proxy, the AOA believes that the agency should conduct a national study of the time physicians spend in nonpatient care GME activities in nonhospital settings. Given the importance of this issue to our members, we also firmly believe that the survey instrument and resulting data should be made available to the public.

Because of our concerns, the AOA joined with the AAMC and the Greater New York Hospital Association to seek an independent analysis of the data from Professor Partha Deb, PhD, Associate Professor of Economics at Hunter College. Dr. Deb was asked to examine the data the AOA and AFMAA submitted to CMS and to provide an expert opinion of the validity of using them to support a national proxy. Although the proposed rule states that the agency relied on its own data, those data were not available to us and are not included in the analysis.

In his analysis, Dr. Deb clearly supports our views in 3 important respects. He states that the AOA data are "extremely unreliable" and should not be used as a basis for a national proxy, certainly not one set at the 3 hour level. Indeed, in his view, none of the data support a 3 hour proxy, including the AFMAA data, which share some of the same problems as those the AOA submitted. Finally, in Dr. Deb's view, CMS should undertake its own national survey to serve as a basis for a realistic physician compensation proxy. A copy of Dr. Deb's analysis is enclosed.

The AOA recommends that CMS establish a proxy of 1 hour. Based on available data, in no event should the proxy be set any higher than 2 hours.

Even if the proxy were appropriate, however, the way CMS has chosen to use it in the formula creates serious additional problems. For example, in response to questions from the AOA, AFMAA and AAMC, CMS stated that the 3 hour proxy never should be prorated no matter how much time residents spend in a nonhospital setting. According to the agency, there is no need to prorate the proxy because the amount a hospital will be required to pay will be adjusted by prorating other portions of the formula. That result is neither apparent nor intuitive. CMS also indicated that both resident salaries and benefits (and travel and lodging if applicable) and physician compensation should be prorated if residents spend less than a full year training in a nonhospital setting. If the residents spend less than a full week at the setting, however, only resident salaries and benefits may be prorated.

These interpretations raise a number of problems. It is difficult to understand a proposal that assumes physicians spend 3 hours of nonpatient care GME time per week on a per resident basis no matter how much time - 4 hours or 40 - the resident spends in the ambulatory setting. Many residents spend less than a full week – or even a full day – training in a particular nonhospital setting. Residents routinely rotate to several different ambulatory sites in the course of a week. Given training realities, the agency's interpretation creates anomalous results. The following examples illustrate the problem.

In each of these examples, assume that resident stipends and benefits are $60,000, the supervising physician's salary is $170,000, the nonhospital setting is open 50 hours per week, and the ratio of residents to physicians is 1:1.

Example 1. Assume that 1 FTE resident spends a full year (all week for a full year) at the nonhospital setting.

Step 1: Calculate the portion of the teaching physician's salary associated with nonpatient care teaching activities:

(3/50) x ($170,000) = $10,200

Step 2: Calculate 90% of the total training costs at the nonhospital site:

.90 x (resident's salary and benefits + supervising physician cost)

.90 x ($60,000 + $10,200) = $63,180 = the 90% threshold

Step 3: Because the hospital already has paid $60,000 in resident salary and benefits, subtract $60,000 from the 90% threshold:

$63,180 - $60,000 = **$3,180** = the amount the hospital would be required to pay the nonhospital setting in order to count the FTE resident.

Example 2. Assume that 1 FTE resident spends 6 months (all week for 26 weeks) training in the nonhospital setting.

Step 1: Calculate the portion of the teaching physician's salary associated with nonpatient care teaching activities:

(3/50) x ($170,000/2) = $5,100

Step 2: Calculate 90% of the total training costs at the nonhospital site:

.90 x (resident's salary and benefits + supervising physician cost)

.90 x ($60,000/2 + $5,100) = $31,590 = the 90% threshold

Step 3: Because the hospital already has paid $30,000 in resident salary and benefits for the time the resident spends in the nonhospital setting, subtract $30,000 from the 90% threshold:

$31,590 - $30,000 = **$1,590** = the amount the hospital would be required to pay the nonhospital setting in order to count the FTE resident.

Explanation: In this example, both the resident salary and benefits and the physician compensation would be prorated because the resident spends all week each week for 6 months training in the nonhospital setting.

In contrast, however, consider the following example:

Example 3. Assume that 1 FTE resident spends 2 ½ days a week at the nonhospital setting for a full year.

Step 1: Calculate the portion of the teaching physician's salary associated with nonpatient care teaching activities:

(3/50) x ($170,000) = $10,200

Step 2: Calculate 90% of the total training costs at the nonhospital site:

.90 x (resident's salary and benefits + supervising physician cost)

.90 x ($60,000/2 + $10,200) = $36,180 = the 90% threshold

Step 3: Because the hospital already has paid $30,000 in resident salary and benefits for the time the resident spends in the nonhospital setting, subtract $30,000 from the 90% threshold:

$36,180 - $30,000 = **$6,180** = the amount the hospital would be required to pay the nonhospital setting in order to count the FTE resident.

Explanation: According to CMS, only the resident's salary and benefits may be prorated in this example. The physician's compensation may not be prorated because the resident does not spend the full week training in the nonhospital setting. As a result, the hospital would be required to pay almost twice as much for an FTE resident that spends 2 ½ days in the setting as when the resident trains in the setting for twice as long (see Example 1.) This interpretation makes little sense. If implemented, it could create serious disruptions to resident rotations, which are arranged to assure that training satisfies the accreditation standards of the resident's specialty. Concentrating training in full week blocks also could negatively affect the availability of private practice physicians to supervise residents in nonhospital settings. Even if Medicare nonhospital policies ultimately are about payment, not medical education, it makes little sense for the federal government to adopt rules that undercut the quality of the programs that train our nation's physicians.

As these examples illustrate, CMS' interpretation of the proposed formula leads to irrational results. Results that are a great deal more reasonable could be achieved by simply aggregating the time residents spend in a setting on a yearly basis before the formula is calculated.

To illustrate, in Example 3 above, the resident spends ½ week at the nonhospital setting each week for a full year, which is the equivalent of ½ year. The amount the hospital must pay the setting would be calculated as in Example 2. As in that example, the hospital would be required to pay $1,590.

If the proposed rule is finalized, the AOA recommends that CMS allow aggregation of resident time spent in the nonhospital setting as the first step in the payment calculation. A number of carefully crafted, step by step examples illustrating these calculations should be included in the final rule.

Hours the Nonhospital Setting is Open

Current Medicare policies require teaching hospitals to calculate physician supervisory costs based on actual time spent on "nonpatient care GME activities" and physician-specific salary information. In lieu of actual time, the proposed rule would allow teaching hospitals to calculate the portion of physician compensation attributable to direct GME activities by dividing the 3 hour proxy by the total number of hours the nonhospital site is open per week. Even if the 3 hour proxy were reasonable, which the AOA challenges, dividing it by the number of hours the site is open is arbitrary, inappropriate and ambiguous. At a minimum, if this proxy is adopted, CMS should include a definition of "hours open" in the final rule, specifying what documentation would be required.

In lieu of using the number of hours the site is open as the denominator, the alternative methodology could establish the relationship between nonpatient care GME activities and physician effort by dividing the former by average physician hours per week by specialty. A table showing such data is included in an article published in the *Journal of the American Medical Association* on September 3, 2003. (JAMA, Vol. 290(9), 1173-1178.) The AOA asks that CMS consider this approach rather than using the number of hours the site is open per week in the payment calculation.

National Average Physician Compensation

Current Medicare policies require teaching hospitals to calculate physician supervisory costs based on actual time spent on "nonpatient care GME activities" and physician-specific salary information. These policies have created a number of problems. Salary information often is difficult to obtain because physician practices are understandably reluctant to share compensation arrangements with outside parties. Basing payment for medical education on patient care revenues is inequitable and inappropriate. Collecting physician-specific data and paying supervisory physicians on that basis is time consuming and administratively burdensome.

In response to these concerns, the proposed rule would allow hospitals to use physician compensation survey data as a proxy for actual salary information. The AOA appreciates this proposal, which would provide an alternative where individual salary information is unavailable. It also would reduce administrative burdens and treat physicians equitably within specialties.

CMS suggests that the salary survey data that are adopted should be comprehensive, issued annually, available free of charge, and come from a nationally recognized source. These criteria are reasonable in light of the way the data would be used. CMS also invites comments on whether it should require the use of mean or median data, whether the data should be regionally adjusted, and whether the rule should specify the use of data from the AMGA or an alternative source.

The AOA believes that median physician compensation data should be used for this purpose. Median compensation is a better measure of the compensation typically received by practicing physicians. Because physician compensation varies substantially from physician to physician, even within the same specialty, the AOA recommends that CMS strongly consider using regionally-adjusted data.

Although salary survey data available from the AMGA are annual and comprehensive, they also are proprietary, requiring payment of a fee for access to the information every year. Alternative sources of these data such as MGMA, Hay, Sullivan-Cotter, and others, also involve a cost for the user. In the AOA's view, it is not appropriate for CMS to propose an alternative methodology that imposes additional costs on medical education – unless those costs are explicitly recognized in Medicare GME payment.

CMS also should assure that survey data cover the broadest possible universe of physicians, including those in small practices located in rural and smaller urban areas. According to CMS, the AMGA membership includes 283 medical groups with an average of 272 physicians. Although the AMGA survey is sent to nonmember medical groups as well, only about 218 groups respond to the survey. It is not clear how representative of all practicing physicians these respondents are.

Medicare has long recognized the reasonable compensation equivalents (RCEs) as a standard for physician compensation. The AOA recommends that CMS strongly consider using the RCEs in the formula as the proxy for physician-specific salary information.

Under the Social Security Act, the Secretary of Health and Human Services is charged with determining criteria for distinguishing two types of physician services:

- Professional medical services personally rendered by physicians to individual patients, which are paid for under Medicare Part B; and

- Professional services that are rendered for the general benefit of patients, which are paid on a reasonable cost basis under Medicare Part A.

Social Security Act §1887(a); 42 USC §1395xx(a).

The latter category includes provider-based physician services such as those provided by anesthesiologists, radiologists, pathologists, and teaching physicians. Payment for these services is determined on the basis of the time spent rendering the services. Payment amounts are limited by the RCEs, which were developed in accordance with a methodology that considers average physician income by specialty and type of location. According to the Medicare Provider Manual, the RCEs represent reasonable compensation for a full-time physician. Conditions of Payment for Costs of Physicians' Services to Providers (*Prov. Reimb. Man.,* Part 1, §2182.6 (A)(4)(C)).

For graduate medical education purposes, private practice physicians who supervise residents in nonhospital settings act as an extension of hospital-based teaching physicians. Because the nonpatient care GME services they provide are education, not patient care, it is appropriate to base their compensation for these services on the reasonable compensation equivalents.

Other Requirements

Effective Date. If finalized, the proposed rule would change the nonhospital payment requirements to allow the use of an alternative methodology. This methodology could add clarity and reduce administrative burdens. Use of the proposed proxies could provide a measure of assurance that GME payment will not be disallowed because amounts paid to nonhospital settings are challenged retrospectively by the fiscal intermediaries. Establishing a percentage threshold for payment better embodies the statutory mandate, which requires payment of "all or substantially all" of the training costs in the nonhospital setting (emphasis supplied.)

In order to make this methodology available to our members as quickly as possible, the AOA recommends that CMS make the final rule effective immediately for portions of cost reporting periods occurring on or after July 1, 2007.

Written Agreements. Under current requirements, a hospital either must enter into a written agreement with a nonhospital setting before training begins or pay all or substantially all of the training costs concurrently, (i.e., by the end of the third month following the month in which training occurs.) The current written agreement requirement is unduly rigid.

There is no legal requirement that an agreement must be signed before performance begins. When the existence of an agreement is demonstrated by the actions of the parties, the law recognizes an enforceable contract based on the course of their dealings. If the existence of a training arrangement can be established after the fact by concurrent payment, it makes little sense to deny payment when an agreement is ratified at any time during the term of the agreement. At a minimum, the agency should recognize the presence of a binding agreement as of the time it is executed by all parties.

Related Matters

Hospitals Over the Cap. According to the statute, a teaching hospital may count the time residents spend in nonhospital settings if the residents are engaged in patient care activities and the hospital incurs "all or substantially all" of the costs of training in that setting. Data indicate that approximately 400 hospitals currently are over their cap(s), training more residents than they are permitted to count for Medicare direct or indirect medical education purposes. If the proposed rule is finalized, CMS should specify whether nonhospital payment requirements apply to the additional residents and how training for these residents should be documented.

Summary and Recommendations

The AOA appreciates the agency's willingness to propose an alternative methodology for determining "all or substantially all" of the costs of training in nonhospital settings. Although this methodology does not address the underlying problem, it provides much needed clarity and predictability in an area that has created serious concerns for our members for the last five years. For the reasons set forth in this letter, the AOA recommends that CMS:

- Reduce the 90% threshold, requiring payment of 75% of the costs of training at the nonhospital site calculated in accordance with the alternative methodology or current Medicare requirements.

- Change the 3 hour presumptive measure of nonpatient care GME activities to 1 hour, which more accurately reflects the time physicians spend on such activities on a per resident basis.

- Allow aggregation of resident time at a site on a yearly basis when residents spend less than full weeks or days in a nonhospital setting.

- Permit the use of average physician work hours by specialty instead of (or as an alternative to) the number of hours a nonhospital setting is open per week.

- Specify the use of the reasonable compensation equivalents as a proxy for physician-specific salary information. In the alternative, CMS should assure that median regionally-adjusted data are available free of charge for use in the nonhospital formula.

- Make the final rule effective immediately for portions of cost reporting periods occurring on or after July 1, 2007.

Although this proposal does not resolve the underlying problem, it is a significant first step toward greater clarity and predictability. The AOA appreciates this step and remains committed to working with CMS and Congress to bring this matter to a final resolution.

If you have questions about our comments, please contact Margaret Hardy, Director of Hospital and Medical Educator Affairs, at 202 414-0155 or mhardy@osteopathic.org.

Sincerely,

John A. Strosnider, DO
President

Enc.

cc: Philip B. Ajluni, DO, President-Elect
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March 26, 2007

Leslie Norwalk, Esq.
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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.

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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

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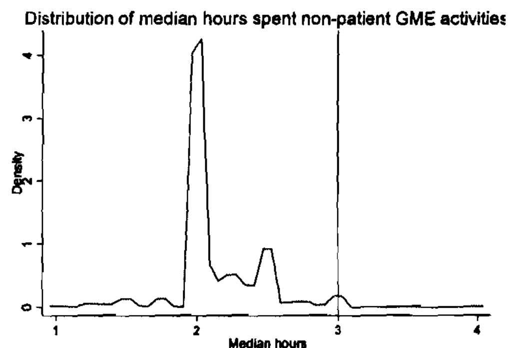
Table 3

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

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VIA HAND DELIVERY

March 26, 2007

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Attention: **CMS—1529—P: PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION**

Dear Administrator Norwalk:

The Association of American Medical Colleges (AAMC or the Association) welcomes this opportunity to comment on the proposal by the Centers for Medicare & Medicaid Services (CMS or the Agency) to modify its policies for when hospitals can claim the time that residents train in nonhospital settings for purposes of receiving Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments. This proposal was included in the proposed rule on the long-term care hospital prospective payment system for rate year 2008 (72 Fed. Reg. 4776, 4818 (February 1, 2007)). The Association's Council of Teaching Hospitals and Health Systems (COTH) comprises nearly 300 general acute nonfederal major teaching hospitals and health systems that receive DGME and IME payments. The Association also represents all 125 accredited U.S. allopathic medical schools; 94 professional and academic societies; 90,000 full-time clinical faculty; and the nation's medical residents and students.

This proposed rule is of great import to the academic medical community. As medical educators seek more opportunities for residents to train in ambulatory settings, it is critically important that such efforts be accompanied by needed Medicare financial support—support that has been authorized by Congress—and that the accompanying rules not impose unreasonable administrative burdens in order to receive that support.

MEDICARE SUPPORT FOR NONHOSPITAL RESIDENCY TRAINING

Medicare's explicit support for residency training in nonhospital sites goes back nearly 20 years. In the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509), effective July 1, 1987, Congress authorized DGME payments associated with the time residents spend training in nonhospital sites so long as the hospital incurred "all, or substantially all, of the costs for the training program in that setting." (Social Security Act, Section 1886(h)(4)(E)). In the Balanced Budget Act of 1997, Congress expanded Medicare support for this training by allowing hospitals to claim this time for purposes of receiving IME payments as of October 1, 1997, again so long as the hospital incurred "all or substantially all" of the residency training costs at the site.[1] (Social Security Act, Section 1886(d)(5)(B)(iv)).

In enacting and implementing these legislative mandates, both Congress and CMS (and its predecessor, the Health Care Financing Administration), expressed strong support for this training. The House budget report accompanying the 1986 legislation states that "[i]t is the Committee's view that training in [ambulatory] settings is desirable, because of the growing trend to treat more patients out of the inpatient hospital setting and because of the encouragement it gives to primary care." (House Report 99-727). The BBA conference report notes concern "about the lack of current data on the number of residents receiving training in ambulatory care sites." And, as recently as April 2005, CMS expressed strong support for this training in a Question and Answer Document: "CMS acknowledges the value of training more residents in nonhospital sites and it is our intent to make sure our rules encourage and facilitate this kind of activity." (See "Medicare Policy Clarifications on Graduate Medical Education Payments for Residents Training in Nonhospital Settings" (Q and A Document), April 8, 2005.)

We appreciate the support expressed by both the Congress and CMS for residency training at ambulatory sites. These sites include physician offices, nursing homes, and community health centers. They provide important educational experiences because of the broad range of patients and conditions treated. Such training also is critical to residents' preparation for medical practice, ensuring they will be exposed to settings where they may ultimately practice.

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[1] The IME limit is determined by the number of FTE residents who were training in the inpatient setting only during the base year (1996). This is because in 1996 hospitals could not claim resident time in nonhospital sites for IME payment purposes. Thus, it is not possible for a hospital to increase the number of residents that it can count for IME payments by moving residents to a nonhospital site; it can only alter the share of residents training in the hospital versus nonhospital site. The IME resident cap is set, and no matter how many residents may be in a nonhospital setting, they can only be counted to the extent that the count does not exceed the 1996 cap. The intent of the BBA was to avoid penalizing hospitals, by reducing their IME payments, that wished to move their residents from an inpatient to a nonhospital setting.

RECENT REGULATORY HISTORY

Up until1999, the Medicare regulations specified that a teaching hospital could meet the legislative "all or substantially all" requirement if it incurred residents' stipends and benefits for the time spent at the nonhospital site. Effective January 1, 1999 CMS unilaterally changed its policy to require that, in addition to incurring the residents' stipends and benefits, the hospital also would need to incur any supervisory physician costs to receive DGME and IME payments.

While we believe the pre-1999 regulations fully complied with the "all or substantially all" statutory requirement, we acknowledge that the 1999 regulatory change requires the hospital to pay supervisory costs, if any, that are incurred by the nonhospital site.

Since 1999, however, CMS and the academic medical community have diverged in their views about how to handle "volunteer" supervisory physicians for purposes of determining supervisory costs, as well as the level of supervisory costs that hospitals must incur in order to meet the "all or substantially all" requirement. The academic medical community has a long tradition of physician volunteers. We believe that through negotiation the hospital and nonhospital site should determine whether there are supervisory costs and, if so, the level of those costs. Further, if physicians state they are volunteering as supervisors, CMS should allow the hospitals to claim the resident time in those sites without requiring that they pay supervisory costs.

However, in discussions with CMS staff, we understand that the Agency has established its policy based on its interpretation of the "all or substantially all of the costs" legislative language which they believe require a determination of the actual cost to the nonhospital site for the teaching physician's time spent on GME activities and a corresponding requirement that hospitals incur this cost in order to receive Medicare reimbursement.

In 2005, in response to questions and concerns raised by the academic medical community, CMS issued the Q and A Document in an attempt to clarify its policies regarding when teaching hospitals must pay supervisory costs to nonhospital sites and how those amounts are to be determined. Unfortunately, from the perspective of the teaching community, while this document clarified some issues, it raised a host of others (see April 15, 2005 letter from AAMC President Jordan Cohen, M.D., to CMS Administrator Mark McClellan, M.D., Ph.D.). In one particularly important area, the Q and A Document appeared to specify that the level of supervisory costs that the hospital needs to incur must be determined by obtaining the teaching physician's salary and knowing the precise amount of time that he or she spends on supervisory activities that do not involve patient care.

Many teaching hospitals and nonhospital settings were frustrated with the requirements contained in the Q and A Document because they failed to recognize the role of volunteers in resident education. The also created significant compliance difficulties in

a) obtaining actual physician salary data, and b) computing the amount of physician time spent supervising residents that does not involve patient care activities.

PROPOSED RULE

As described by the Agency, the goal of the proposed rule is to be responsive to "concerns expressed by the teaching hospital community about the administrative burden associated with determining and documenting that hospitals are paying for 'all or substantially all' of the costs for the training in the nonhospital setting" (72 Fed. Reg. at 4820).

In brief, the proposed rule would make the following changes to current policies regarding residents training in nonhospital sites:

- Modify the regulatory definition of "all or substantially all" to mean 90 percent of the sum of residents' stipends and benefits plus physician supervisory costs at the nonhospital site rather than the current 100 percent standard;

- Give teaching hospitals the option of using national physician salary data in the calculation of supervision costs, rather than requiring them to obtain actual salary data from each supervising physician; and

- Establish a "presumptive" level of time that supervising physicians spend on nonpatient care resident supervision activities. Hospitals and supervising physicians can use this time proxy to calculate supervisory costs rather than obtaining actual supervision time levels for each physician at each site.

THE AAMC'S OVERARCHING VIEWS OF THE PROPOSED RULE

The AAMC very much appreciates the time that both CMS GME staff and senior level officials have devoted to this issue, including multiple discussions with the AAMC and other representatives of the academic medical and GME communities.

Unfortunately, the proposed rule is not the "solution" that we and our members were hoping for because it does not recognize that many physicians are willing to volunteer as supervisors, with the concomitant result, we believe, that the hospital need not pay any supervisory amounts. Volunteerism has always been part of the tradition of physician education, which is why many physicians oppose CMS's position. Moreover, both physicians and institutions alike recognize that to the extent that hospitals have to pay supervisory costs to nonhospital sites, there are less financial resources available that can be used for other important educational initiatives.

However, we acknowledge that CMS's position is based on the constraints the Agency believes arise from the "all or substantially all" statutory language. Consequently, it is

clear that the volunteer issue and the definition of "all or substantially all" must be clarified by Congress and we will continue to seek that clarification.

Setting aside our fundamental disagreement regarding the interpretation of the statute, we believe the proposed rule has the potential to result in significant improvements compared to CMS's current policy. Foremost among these is the recognition that hospitals need not incur 100 percent of the nonhospital costs in order to meet the "all or substantially all" cost requirement. The "alternative methodology" and proposed proxies also may provide significant administrative relief for most, if not all, teaching hospitals and nonhospital sites.

We cannot overestimate the administrative burden that the current policies place on hospitals and nonhospital sites. We appreciate that CMS also recognizes this burden, as demonstrated by developing this proposed rule. However while the proposed rule reduces certain burdens, it also introduces new ones.

Our common goal in this rulemaking process is a final rule that the Agency agrees meets with its interpretation of the statute but imposes the least administrative burden possible. We hope and believe that the specific comments we provide will help move us down that collective path. As CMS has articulated on many occasions, Medicare policies as much as possible should not alter educational decisions or the design of residency programs. We agree wholeheartedly with this sentiment and are eager to work with CMS to achieve an outcome that fulfills this mutual objective.

AAMC MEMBERS' NONHOSPITAL SITE RESIDENCY ROTATIONS

We have spent significant time discussing nonhospital site rotations with GME leaders at our member teaching hospitals and medical schools. The primary message they conveyed was that there is no "typical" nonhospital site rotation. Rotations can last for as long as a month or a week, but commonly are less than a week. Often the rotation site and length is dictated by accreditation standards. For example, the internal medicine residency program standards require that residents spent a half day a week "in a continuity ambulatory experience (continuity clinic) managing a panel of general internal medicine patients." (Internal Medicine Residency Program Requirments on ACGME web site at http://www.acgme.org/acWebsite/RRC_140/140_prIndex.asp)

Residency programs also may have residents spend half day rotations at subspecialty clinics to expose them to other practice areas. We have been told that it is not uncommon for residents to do multiple rotations at multiple nonhospital sites in a given week.

Other information obtained from our GME leaders include:

- Teaching hospitals develop and maintain relationships with over 100 nonhospital sites in order to provide ambulatory training experiences for hundreds of residents.

- Nonhospital sites are not always identified at the beginning of the academic year but frequently are arranged on a short-time turn-around basis; for example, a resident may need to receive a specific educational experience required to complete his/her residency.

- Identifying nonhospital sites may become even more ad hoc in the future as residency programs are being encouraged by the accreditation body to find innovative ways to train residents.

- Relatively few solo practitioners train residents. Far more common is a group practice where one physician is designated as the site supervisor, but multiple physicians at the site will work with the resident(s).

- Supervising physicians usually are volunteers. They may receive some form of recognition, such as a faculty appointment.

- Among the reasons that physicians willingly volunteer is that they are loyal to the training program (they may have trained in the same program) and they enjoy teaching. Family practice physicians receive credit for teaching that is applied to re-certification. In smaller and rural practices, teaching allows physicians to feel more connected to others in their profession, to keep up with the latest medical advances, and may help recruit and retain residents who often stay in a practice where they trained.

Many of the conclusions reached by the HHS Office of Inspector General (OIG) in the 2004 report, *Alternative Payment Methodologies for the Costs of Training Medical Residents in Nonhospital Settings* ((A-02-04-01012), are consistent with the information provided by the GME leaders. For example, the OIG stated that:

> Of the 120 nonhospital settings visited, 95 (79 percent) had a physician or physicians who told us that they voluntarily supervised residents in nonhospital settings. Both the nonhospital setting officials and the supervisory physicians indicated that no compensation was involved with the volunteerism. Additionally, supervisory physicians indicated they were not coerced into volunteering their time to supervise residents (page 6).

SPECIFIC COMMENTS ON THE PROPOSED RULE

A. Definition of "All or Substantially All" Nonhospital Training Costs (72 Fed. Reg. at 4820-22)

The proposed rule would establish a new definition for "all or substantially all of the costs for the training program in the nonhospital setting" at 42 C.F.R. §413.75(b):

"Effective for cost reporting periods beginning on or after July 1, 2007, at least 90 percent of the total costs of the residents salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries attributable to direct GME."

Rather than the current 100 percent level, the proposed rule would require teaching hospitals to incur only 90 percent of the total nonhospital costs and no more. This means that if the residents' stipends and benefits incurred by the hospital comprise 90 percent of the total costs, the hospital need not pay any supervisory costs for Medicare reimbursement purposes. 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 (see 72 Fed. Reg. at 4821).

According to the proposed rule, the 90 percent threshold is to be determined according to the following formula:

90% Threshold = (0.90) * [(sum of each FTE resident's salary + fringe benefits (including travel and lodging where applicable)) + (the portion of the teaching physician's compensation attributable to direct GME activities)].

We appreciate and support CMS's proposal to redefine the definition of "all or substantially all" to reduce the cost threshold. However, we believe that the threshold could be further reduced and still meet the statutory definition. Specifically, we believe there is precedent within Medicare to set the threshold at 75 percent.

CMS has defined "substantially all" as being 75 percent in the context of financial relationships between physicians and entities furnishing designated health services—the "Stark" provisions. 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, requires that each physician member of a group practice must furnish "substantially the full range of services which the physician routinely provides" on an individual basis and that a group practice is an association "for which substantially all of the services" of group member physicians are furnished through the group "and are billed in the name of the group." 42

U.S.C. §1395nn(h)(4)(A), (B). In interpreting the statute, CMS stated in its initial proposed rule that "the word 'substantial' generally means a considerable amount," and that 85 percent would constitute "substantially all" of an amount. 57 Fed. Reg. 8588 (March 11, 1992). Later, CMS lowered the threshold for "substantially all" to 75 percent, a standard which remains in effect today. 42 C.F.R. §411.352(d); 60 Fed. Reg. 41914, 41931 (Aug. 14, 1995); 66 Fed. Reg. 856, 904 (Jan. 4, 2001).

It is a standard rule of interpretation that the same term should be defined the same way within a single statutory scheme. CMS has already interpreted "substantially all" in the context of the Social Security Act as meaning 75 percent (and notably started at 85 percent, lower than the 90 percent proposal in this instance). Indeed, the issues are very close since both laws focus on physician practices—in the nonprovider site statute, Congress refers to the costs of a *physician practice*; in the Stark law, Congress refers to the services of a *physician practice.* There is no justification based on the law or in underlying policy to interpret "substantially all" differently in the nonprovider site context than for Stark purposes.

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 and the courts' interpretations of the term "substantially all" as being 75 percent or greater, we believe the 90 percent threshold should be adjusted to 75 percent, consistent with its current practice.

B. Determining Physician Supervisory Costs Attributable to Direct GME Activities

Under the proposed rule, supervisory physician costs exist only when physicians receive a "predetermined payment amount, such as a salary." According to CMS, this predetermined amount reflects all of the physician's responsibilities at the nonhospital site including "treating patients, training residents, and other administrative activities" (72 Fed. Reg. at 4821). Thus, CMS concludes that the predetermined compensation amount "*implicitly* also compensates the physician for supervising residents" (emphasis added), which must be paid by the hospital (Ibid.). (See discussion on group practices, below). Consequently, to the extent residents are training in nonhospital sites in which the supervising physician is a solo practitioner, or in a group practice setting in which the physicians do not receive predetermined compensations but rather only share overhead expenses, such as electricity and rent, there are no supervisory costs that the hospital is required to pay to comply with the Medicare rules.[2]

[2] According to the proposed rule 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." (72 Fed. Reg. at 4821). When the solo practitioner is not treating patients, for example when engaged in didactic activities with residents, he/she is receiving no compensation. Therefore, under CMS's

The amount of physician supervisory costs that is included in the 90 percent threshold calculation is based on the share of the teaching physician's salary that is "attributable to direct GME" (72 Fed. Reg. at 4821).

Such a determination requires a) understanding what constitutes "direct GME activities," and b) calculating the physician costs that are devoted to these activities.

1. "Direct GME Activities"

The proposed rule interchangeably uses the phrases "direct GME activities," "nonpatient care activities," and "activities related to non-billable GME activities" to describe the activities for which the hospital must pay supervisory costs. None of these phrases aer defined in regulation, but the preamble states that examples include "conferences, practice management lectures, and administrative activities like resident evaluations" (72 Fed. Reg. at 4826) The 2005 Q and A Document provides further information about the definition of this phrase:

> "With respect to the compensation for teaching physicians, the hospital is required to compensate the nonhospital site for the costs of the teaching physician's activities provided in connection with an approved residency program other than the supervision of residents while furnishing billable patient care services. That is, only the costs associated with teaching time spent on activities within the scope of the GME program, but not in billable patient care activities, would be considered direct GME costs that would need to be incurred by the hospital." (CMS Q and A Document, Number 3).[3]

Given the importance of this phrase, we believe CMS should give serious consideration to including a definition of it in the final regulation. Doing so would give parties a definitive source that they could refer to when they are seeking to comply with the nonhospital training requirements.

2. Calculating Physician Supervisory Costs

Under CMS's current policy (as explained in the Q and A Document), the amount of supervisory costs that must be incurred by the hospital is determined by multiplying the

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interpretation, there are no direct GME supervisory costs that the hospital must incur in order to qualify for Medicare DGME or IME payments. Similarly, if in a group practice the physicians only share overhead expenses, such that their respective payments are based only on the patients treated, they essentially are functioning as solo practitioners and therefore there are no supervisory costs that the hospital must incur.

[3] Q and A Document, Number 5 provides additional examples of activities that are considered non-billable GME activities: "general clinical didactic training or assessing the resident's performance."

teaching physician's salary and the percentage of time he/she devotes to activities related to non-billable GME activities at the nonhospital site. (CMS Q and A Document, Number 5).

As discussed above, many teaching hospitals and nonhospital settings have been frustrated with the requirements contained in the Q and A Document because they impose almost impossible compliance difficulties in a) obtaining actual physician salary data, and b) computing the amount of time the physician spends supervising residents that does not involve patient care.

Recognizing these concerns, the proposed rule would give teaching hospitals the option of using the current method, or a method that CMS defines as a "short cut" (72 Fed. Reg. at 4821-28). The shortcut involves utilizing a national physician salary amount (from an authorized source), and a CMS-determined "presumption" of the amount of time that the teaching physician spends in nonpatient direct GME activities. The presumption included in the proposed rule is that the supervising physician spends three hours in nonpatient care direct GME activities per week. We understand that under the proposed rule the three hour standard would be used in all supervisory cost determinations, regardless of the nonhospital site, length of rotation, specialty of the residents, or the number of supervising physicians or residents at the nonhospital site.

The percentage of the physician's salary associated with those three hours would be determined by dividing the three hours by the number of hours the nonhospital site is open each week.

The proposed rule notes that a teaching hospital could choose to use all of the proxies or only a subset. For example, the hospital could use national physician salary data, but use actual non-billable GME time rather than the three hour presumption.

a. National Physician Salary Data (72 Fed. Reg. at 4823-24)

Under the proposed rule, hospitals would be allowed to use national physician salary data as a proxy for the supervising physician's actual annual salary. CMS specifically mentions the annual compensation survey conducted by the American Medical Group Association (AMGA) as one possibility, but seeks comments about other data sources that might be more appropriate.

b. Medicare "Reasonable Compensation Equivalents" (RCEs)

We recommend that for consistency CMS employ its own already-established "reasonable compensation equivalent" ("RCE") limitations as a proxy for physician salaries. The RCEs have been relied upon by CMS and its predecessor, the Health Care Financing Administration, for nearly 24 years as its measure of the reasonableness of physician compensation and, thus, those amounts should be used in this regulation as well.

In 1982, Congress amended the Medicare statute to direct the Agency to reimburse only those physician compensation amounts that are "reasonable," and directed the Secretary to create "reasonable compensation equivalent" ("RCE") limitations for physician compensation costs. CMS first established RCE limitations 24 years ago, and has directed its intermediaries to apply those limitations (as updated) from then to the present. 42 C.F.R. §415.70, *see also* 48 Fed. Reg. 8903 (March 2, 1983).

The RCEs are not of historic use 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 also are teaching hospitals.) For purposes of cost reimbursement, CMS will not allow physician compensation in excess of the RCEs. If CMS were to use the AMGA data cited in the proposed rule as its proxy for the amount of costs in nonhospital 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 is somewhere between $150,200 and $165,600, 68 Fed. Reg. 45346, 45459 (Aug. 1, 2003), depending on the geographic area where the cardiologist practices.[4] 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-- the costs incurred by teaching hospitals for supervising physicians in nonhospital sites are costs that are properly reported in the interns and residents cost center on a teaching hospital's cost report and which 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. We have been advised by legal counsel that requiring the use of physician compensation data in this rule that are higher than CMS's limitations on reasonable costs for physician compensation in other regulations could be viewed as "arbitrary and capricious."

c. AAMC Faculty Salary Survey

If CMS decides there are valid reasons that preclude the use of RCEs, we believe data from the AAMC's Faculty Salary Survey should be seriously considered as the data source.

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

The 2005-2006 survey report (*"Report on Medical School Faculty Salaries, 2005-2006"*) (Faculty Salary Survey) includes data provided by all 125 accredited allopathic medical schools in the United States. The survey collects data on both clinical and basic science faculty.[5] However, not all medical schools reported all of their faculty salaries; for full-time clinical faculty with an M.D. or equivalent degrees, a comparison with the AAMC's Faculty Roster suggests there was a 72 percent coverage of individuals across all specialties.

The Faculty Salary Survey results show the total annual compensation[6] for 56,620 full-time faculty in 63 clinical departments.[7] Although the Faculty Salary Survey departments are not defined in the same manner as specialties, they are a close proxy. We believe the use of departments is more appropriate for describing medical school faculty compensation and is discrete enough to encompass specialties that would satisfy CMS's requirement for a wide range of specialties.

CMS is proposing to use the American Medical Group Association's (AMGA) *"2006 Medical Group Compensation and Financial Survey."* The AMGA report presents summary statistics for total annual compensation by specialty and region for 34,897 physicians in approximately 108 specialties.

The AAMC has prepared a comparison chart for selected specialties (Table 1) to assist in evaluating the pros and cons of the two data sources. Overall, the number of AAMC clinical responses is higher than the AMGA survey: 56,620 compared to 34,897. For many specialties, the AAMC's Faculty Salary Survey includes more responses than the AMGA's survey, thereby reflecting a better penetration for those specialties. For example, 17.8 percent of all endocrinologists, 16.7 percent of neurosurgeons, 16.3 percent of all geriatric medicine physicians, and 7.1 percent of general surgery physicians are included in the AAMC's survey while only 6.4 percent of endocrinologists, 4.5 percent of neurosurgeons, 2.8 percent of geriatric medicine and 3.1 percent of general surgery physicians are included in the AMGA's survey. Even for the specialties for which the penetration is lower for the AAMC's survey, the difference is relatively small. For example, 2.7 percent versus 4.2 percent for family medicine physicians and 3.6 percent versus 4.2 percent for internal medicine. Table 2 presents the mean and median values for selected specialties based on the AAMC Faculty Salary Survey data.

Again, while we prefer the RCEs, if they are rejected we urge CMS to give serious consideration to using data from the AAMC faculty survey. The AAMC data have relatively high response rates and reflect a broad range of specialties. Many of the

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[5] While the Report contains both clinical and basic science faculty, the AAMC could provide CMS with the clinical faculty data only.

[6] Total compensation equals the actual fixed/contractual salary component of total compensation plus the actual supplemental earnings components of total compensation (medical practice supplement, bonus/incentive pay, and uncontrolled outside earnings).

[7] As of December 31, 2005, the AAMC Faculty Roster showed approximately 79,143 full-time clinical faculty in the U.S.

supervising physicians in nonhospital sites are either full-time faculty or have faculty appointments. Moreover, because they are serving in a faculty capacity, the salary that should be used for the supervision cost determination should be based on faculty salaries.

d. Other Physician Salary Issues

CMS also is seeking comments as to whether to use mean or median compensation amounts, and whether geographic variations in physician salaries should be accommodated.

In general, we tend to favor medians because they reduce the influence of outlier data. Using medians seems particularly desirable when the data involve relatively low response rates because the influence of outliers is more pronounced in those instances. It also is noteworthy that the RCEs are based on the 50th percentile (median) of physician compensation. To the extent that CMS opts to use physician compensation data other than the RCEs, at a minimum it should follow its precedent of using the median of reported data.

While in general we believe the data should reflect local situations, it is unclear whether the data are easily available by geographic region, or whether such data are stable over time. Given that the purpose of the proxy is to best "approximate" actual salaries, we believe to the extent individual hospitals identify sources that provide median physician salaries that are representative of their geographic area they should be permitted to use such sources.

3. Determining the Share of Physician Salaries Associated with Direct GME Activities

As discussed above, CMS proposes that hospitals may use a proxy for determining the physician cost share. The proxy is a ratio in which the numerator would be three, representing a presumptive number of nonpatient care supervising hours per week, and the denominator would be the number of hours the nonhospital site is open per week.

This ratio is a key determinant of the supervision cost calculation. For example, if the nonhospital site is open 40 hours a week, 7.5 percent (3/40) of the physician salary amount is the supervision cost amount that must be included in the 90 percent threshold calculation. If the nonhospital site is open 60 hours per week, the percentage would be 5 percent (3/60). This difference is significant, particularly when one considers the number of nonhospital sites with which a teaching hospital relates. If, for example, the physician's annual salary is $200,000, the annual supervisory cost calculation would equal $15,000 if the ratio is 7.5 percent, which is $5,000 more than the $10,000 amount that a 5 percent ratio would yield. With some teaching hospitals working with over 100 nonhospital sites this difference is not insignificant.

Below we provide our views about both the numerator (the three hour supervision time presumption) and the denominator (the hours that the nonhospital site is open during the week). We then discuss the overall ratio since, along with the physician salary, it is the ultimate determinant of supervision costs.

a. The Ratio's Numerator—The Three Hour Per Week Nonpatient Supervision Activity Presumption

CMS states in the proposed rule that "the standard of 3 hours of nonpatient care GME activities per week is a reasonable proxy based on data collected from surveys conducted by the Association of American Medical Colleges (AAMC), the American Osteopathic Association (AOA) and the Academic Family Medicine Advocacy Alliance (AFMAA), in addition to information compiled from our own informal surveys of teaching physicians" (72 Fed. Reg. at 4826).

First, we would like to clarify that the AAMC did not provide CMS with survey data. CMS's confusion on this issue may be because these data were provided at a meeting in which AAMC staff were in attendance and we noted that AAMC staff provided some input to the survey questions that were fielded by the AOA and AFMAA.

Second, CMS rightly describes the surveys fielded as "informal" (see 72 Fed. Reg. at 4826). Our understanding is that these surveys were developed and conducted by AOA and AFMAA policy staff without the involvement of persons with specific survey expertise due to time constraints.

At the time the data were provided to CMS, both the AOA and AFMAA staff expressed concerns about the validity of the data results. We defer to comments submitted by AOA and AFMAA that provide more detail about the inadequacy of these data as a basis for establishing national policy.

To provide an independent review of these data, the AAMC, AOA, and Greater New York Hospital Association asked Professor Partha Deb, PhD, Associate Professor Department of Economics, Hunter College, to examine the AOA and AFMAA survey responses and provide his opinion of the validity of these data for establishing a national proxy. Attached is Dr. Deb's letter to CMS. In brief, his letter expresses concerns about the data provided to CMS. He suggests that the Agency should conduct its own study to identify nonpatient care hours. But, in the meantime, if CMS wishes to make a decision based on the AOA and AFMAA survey responses, he believes a more appropriate proxy would be two hours.

Another factor that should be considered is that the AOA and AFMAA surveys were conducted prior to the August 2006 inpatient final rule in which CMS stated that for DGME and IME payment purposes, hospitals may not claim any time that residents spend in nonpatient care activities at nonhospital settings. Since the issuance of that rule,

we have been told by a number of hospitals that these requirements may force them to conduct as much of their didactic activities as possible within the hospital complex.

Given the importance that the supervision proxy plays in the overall cost calculation, we agree with Dr. Deb and urge CMS to hire a survey contractor to conduct a rigorous, national, comprehensive survey of physician nonsupervisory activities.[8] CMS regularly utilizes outside contractors to inform staff on various topics. We believe this decision merits a major effort to ensure the accuracy of this important determination.

Until such data are obtained, we believe CMS should use a proxy value that is at most two hours, based both upon Dr. Deb's analysis and the fact that the survey data were collected prior to the issuance of the August, 2006 inpatient final rule.

It is worth noting that the supervision hour presumption poses difficult interpretation issues. To the extent a resident may spend only a half a day a week at a nonhospital site, the idea that the two or three hours of that time is spent in nonpatient care activities defies conventional logic. This issue can be addressed, however, through a proration process as discussed in more detail below.

b. The Ratio's Denominator—the Nonhospital Site Hours of Operation

The ultimate purpose of the supervisory ratio is to multiply it by a physician salary amount to obtain a supervisory cost amount. Ideally it seems one would want an hours amount that corresponds with the physician salary, since the salary reflects all hours worked, not just those worked in the nonhospital site. The proposed rule seems to agree with this observation[9] but expresses concerns that identifying the true amount would impose additional administrative burdens on hospitals.[10]

Since the goal of this rule is to provide for administrative relief, we suggest that consideration be given to using a proxy for national average total physician work hours in lieu of requiring hospitals to identify and document hours of operation for each site.

While we have not conducted an exhaustive search, we believe that the national data sources on physician work hours are few, but the data that exist appear reasonable. National surveys of physician work hours were routinely included as part of the American Medical Association's (AMA) Socioeconomic Monitoring System (SMS)

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[8] Unfortunately, it does not appear that the OIG obtained information on supervisory hours when it conducted site visits to nonhospital sites as part of its mandated report. HHS Office of Inspector General, *Alternative Payment Methodologies for the Costs of Training Medical Residents in Nonhospital Settings* ((A-02-04-01012) (December 8, 2004).

[9] "We recognize that the teaching physician(s) may not spend 100 percent of his or her time in that nonhospital site. In fact, many teaching physicians spend some of their week working in a hospital or other facilities." 72 Fed. Reg. at 4827.

[10] The proposed rule focuses its discussion on identifying the number of hours that the physician would spend at the nonhospital site, rather than the total hours worked. However, if we understand the concept correctly, we believe that the total hours worked is more appropriate because it parallels the salary data.

studies administered through the 1990's. However, the total number of survey respondents was often low for individual specialties and practice settings and the survey has since been discontinued. The Health Resources and Services Administration (HRSA) used the 1998 SMS to estimate work hours by specialty in its recent physician workforce report (2006); direct patient care hours reported by HRSA range from 47 to 58 hours per week. A more recent study (2005) of physicians over age 50 conducted by the AAMC's Center for Workforce Studies included over 9,000 respondents representative of the US physician population who worked an average of 55 hours per week in all activities, both direct patient care and other activities (full-time respondents). Work hours varied by specialty. For instance, at the lower range, those in Pathology work an average of 50 hours weekly while those in Cardiology average 63 hours per week.[11] These findings are supported by data from the Center for Tracking Health System Change, which reports an average of 53 hours of work per week based upon interviews with approximately 6,600 physicians in all specialties.

Based on these data, we think a reasonable proxy would be 55 hours. However, given the range in work hours across specialties, the best course of action might be to develop specialty-specific proxies, akin to the national survey data approach that CMS is considering.

If CMS decides to retain the clinic hours option, we ask the Agency to confirm that this means the "posted" hours, rather than actual hours (for example, if the site is closed one day due to a holiday).

c. The Overall Supervisory Cost Ratio

Combined with the physician salary amount, it is the supervisory cost ratio that drives the supervisory cost amount that goes into the "all or substantially all" threshold formula. Since the numerator is a fixed number, we believe it could significantly reduce administrative burden if this ratio itself were a fixed proxy amount. As discussed in the previous section, we believe that it is reasonable to allow hospitals to use a national average physician work hours amount of 55. Using this number for the denominator and two hours for the numerator (based on Dr. Deb's conclusion that the best nonpatient care supervision time proxy based on the data provided to CMS is two hours), a maximum fixed ratio "proxy" would be 3.6 percent. Giving hospitals the option of using this fixed percentage could further simplify an already complicated formula.

If CMS rejects this comment, we urge the Agency to include a ratio "cap" in the final rule. We appreciate the fact that CMS recognizes that, if a nonhospital clinic has limited weekly hours, the ratio would be "unusually high teaching costs" and thus solicits comments on this issue (72 Fed. Reg. at 4827). We have heard from our members that some subspecialty nonhospital clinics have very limited hours which would result in the

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[11] In an even more recent survey of physicians under the age of 50, the average weekly work hours reported by thoracic surgeons was 87.

extreme ratios that CMS is concerned about. We urge the Agency to set a "cap" on the ratio to prevent any extreme or atypical cost results and believe a reasonable cap would be no more than 5 percent.

C. Group Practices

The proposed rule confirms that CMS believes there are no supervisory costs for the teaching physician's time if his or her compensation "is based solely and directly on the number of patients treated and for which he or she bills, which is the case of a solo practitioner." (72 Fed. Reg. at 4821). The rule also points out that this compensation arrangement could occur with group practices if, for example if the group only shares overhead expenses and there is no sharing of revenues from patient care activities. (72 Fed. Reg. at 4822).

While we agree with CMS's conclusion regarding the above arrangements, we believe the emphasis of the rationale is misplaced. The fact that the physicians' compensation is derived solely from patient care revenues is not definitive in and of itself. Rather it demonstrates that the physician received no compensation for supervisory activities. It is this latter fact that is the lynchpin for determining whether there are supervisory costs for which the hospital must reimburse the nonhospital site.

Consequently, we believe that it is inappropriate for the Agency to presume "implicit" compensation for supervisory activities when a physician receives a pre-determined salary from a group practice, as the proposed rule asserts.[12] Such a concept seems at odds with the statutory requirement. At a minimum, group practices should be permitted to rebut the "implicit" compensation presumption by demonstrating that no portion of physicians' salaries are linked to resident supervision. For example, if a group practice verifies that 90 percent of a supervising physician's salary is based on the number of patients he sees and 10 percent is due to his managing of the support staff, then there are no "implicit" nonpatient care supervising costs to be reimbursed.

D. Residents Stipends and Benefits

Under the proposed rule, hospitals must incur the salaries and fringe benefits associated with the time the residents spend at the nonhospital site. The proposed rule emphasizes that these costs are based on the FTE number of residents rotating to the site, not the total number of actual residents training at the site. For example, if a resident trains half a year at a nonhospital site, the hospital would be responsible for paying the stipends and benefits associated with a 0.5 FTE. In addition, the rule states that the hospital must use actual costs, which will "vary by specialty and program year" (72 Fed. Reg. at 4826).

[12] Specifically the proposed rule states the predetermined amount "*implicitly* also compensates the physician for supervising residents. A portion of this *implicit* compensation is the cost attributable to teaching activities, and in order to count the residents training at that site, the hospital must pay the nonhospital site this amount." (72 Fed. Reg. at 4821) (emphasis added).

Unlike the current policy, in which it is sufficient to know only that the hospital incurred these amounts and need not know the actual amounts paid, under the 90 percent threshold methodology, it would be necessary for the hospital to document each resident's stipends and benefits. We understand that often residents from different post-graduate years (PGYs) may be training at the nonhospital site at the same time. To comply with the regulations would seemingly require that the hospital know the precise post graduate year of each of the residents training at the site and to prospectively determine the amount of stipends and benefits that it will incur—a significant administrative burden. One alternative would be to allow hospitals the option of using an average stipend plus fringe benefit amount, based on the stipends and benefits of residents in the first three post graduate years (which would reflect the majority of residents training in nonhospital sites). This would allow hospital GME and financial staff to monitor and document only the number of FTE residents and help simplify the formula calculations.[13] We recognize that if only PGY 1 residents are at a site, using an average is not advantageous. However, the administrative relief that this approach provides may outweigh the disadvantages and the hospital would still have the option of using actual data.

E. Computing the 90 Percent Threshold and Proration Issues

We appreciate that CMS has included examples of how the 90 percent threshold would be calculated, as well as the corresponding determination of whether, and how much a teaching hospital would need to pay the nonhospital site in order to meet this threshold.

The year-long examples (see 72 Fed. Reg. at 4823) are helpful to illustrate how the formula would work. However, as described at the beginning of this letter, they rarely reflect actual nonhospital site rotations.

The three month example presented on page 4827 sheds some additional light on how the formula would work because it illustrates the application of the formula when rotations comprise less than a year. According to the example, because the resident is training at a nonhospital site for one-fourth of the year, only 25 percent of the resident stipend plus fringe benefit amount is reflected in 90 percent threshold formula. The example would also prorate the supervisory cost ratio by multiplying it by 25 percent (in the example, this is represented by a supervisory cost ratio of 3/40 times 0.25). This amount is then multiplied by the annual physician salary. Thus, if the physician's annual salary is $200,000, the supervisory cost amount would be $3,740 (3/40 times 0.25 times $200,000).

We find it easier to comprehend this concept by prorating the physician salary rather than the supervisory cost ratio, but the result is the same in both cases. Thus, in the previous

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[13] While seemingly minor, it was pointed out that if residents go to a nonhospital site for a time period that spans June-July, the nonhospital site agreements would need to set forth a cost threshold calculation that has to blend two stipends. Moreover, since the agreements must be done prospectively, hospitals would need to keep track of these situations so that they could modify the stipend amounts accordingly. These administrative burdens would be relieved if hospitals could use one average amount for residents.

example, the same result would be achieved if the 3/40 ratio was not prorated, but only 25 percent of the physician's salary is reflected, or $50,000. By doing it this way, there is a parallelism between prorating both the resident and physician amounts.

The issue of prorating is endorsed by CMS by both the three-month example that is presented as well as the following preamble text: "If FTE resident(s) are not rotating to a particular nonhospital site throughout a whole year, then the national average salary of the teaching physician would be prorated accordingly. The cost of the residents' salaries would already be reflective of an FTE count," (72 Fed. Reg. at 4822).

However, in discussions with CMS staff it seems that the proposed rule means to use the proration principles selectively. Our understanding of the CMS position is that if a resident rotates to a nonhospital site for several days each week over a period of time, the resident's salary and fringe benefits would be prorated, but not the physician's salary. The physician's salary would only be prorated if the rotation occurred in a block situation, such as three months (the proposed rule example).

In Addendum A, we present three examples that we believe illustrate CMS's view and also the flaws inherent in this position. In the first example, a resident rotates to a nonhospital site for six consecutive months, and then spends the rest of the year in an inpatient setting. In the second example, the resident spends two and one-half days a week at a nonhospital site throughout the entire year (an aggregate time of six months), with the remaining time in a hospital setting. In the first example, CMS would prorate both the resident's stipends plus benefits, as well as the physician's salary. In the second example, CMS would only prorate the resident's stipends plus fringe benefits. The result is that even though "in aggregate" the resident spends the same amount of time in the nonhospital site, if he or she rotates in increments of less than a week, the hospital will incur more in supervisory costs. Moreover, because the resident's stipends are prorated, if the resident only spends a half day per week at the nonhospital site (which is common in "continuity clinics" (described above)), the hospital will incur even more in supervisory costs. In other words, the shorter the per week rotation, the higher the supervisory cost amount. Such a result is illogical and must be changed in the final rule.

Example three in Addendum A sets forth CMS's position as it would apply if a resident had five half-day rotations at five different nonhospital sites. Like the previous examples, the aggregate time spent in a nonhospital setting would be two and a half days per week or six months a year. However, if only the residents' salaries are prorated, the result is that the hospital would pay an aggregate supervisory cost of more than $42,000, more than 25 times the amount if the resident had spent six months at a single nonhospital site.

We believe the preamble text of the proposed rule is correct when it states that the physician's salary should be prorated to the extent the resident's salary is prorated. This tenet would ensure equity regardless of the length of the rotation, or how many different sites a resident goes to in any given week. So long as both the resident and physician

salaries are prorated to match the length of time of the rotation, the supervisory cost amount will not be overstated. Alternatively, the three hour presumption could be prorated, rather than the physician salary; this method yields the same result.

F. Clinics Owned By Medical Schools

The 2005 Q and A Document states that "it would be appropriate for the hospital to have a written agreement with the medical school, since the medical school owns the clinics. If the residents are training in various medical school clinics, the hospital must have written agreement(s) reflecting the compensation arrangements for each clinic." (2005 Q and A Document, No. 9; 72 Fed. Reg. at 4829). The proposed rule goes on to say "[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" (72 Fed. Reg. at 4829).

Global agreements between teaching hospitals and schools of medicine are common in academic medical centers. Because of the close relationship between these two institutions, often there are significant sums of money that flow from the teaching hospital to the school of medicine for a myriad reasons, one of which may be to compensate for supervisory costs at the medical school clinic, to the extent there are any. For a variety of reasons, levels of support for specific activities often are not specified.

To the extent there are nonhospital supervisory costs included in a global payment amount, we believe the goal should be to determine a straightforward administrative mechanism to document this, rather than the option contained in the proposed rule which seemingly requires that each and every nonhospital site agreement be attached to the global agreement. This is particularly important because generally global agreements are entered into only once a year, and yet because of the fluidity of nonhospital rotations, hospitals may not be able to provide the nonhospital agreements for the entire year at the time the global agreement is entered into. At a minimum, to the extent that nonhospital site agreements must accompany a global agreement, hospitals should be allowed to make their "best estimate" as to the number and length of these rotations and be permitted to modify them throughout the year as circumstances change.

However, recognizing that the goal of this regulation is to provide administrative relief, we believe that more can be done in the area of global agreements because the issue generally is not whether the hospital is making a payment to the school but documenting that fact. One option that merits consideration is allowing hospitals to use historical nonhospital site rotation experiences to determine an aggregate nonhospital supervisory amount that must be referenced in the global agreement for the upcoming year.

G. Teaching Hospitals That Own the Nonhospital Sites

According to the 2005 Q and A Document, a hospital is required to demonstrate that it is incurring the teaching physician costs even when it owns the nonhospital site or the

nonhospital site is owned by the same organization that owns the hospital (2005 Q and A Document, No. 8). The Document states that the hospital must

> "actually [pay] the nonhospital site through the hospital's accounts payable system. (If the hospital and nonhospital site share a single accounting system, the hospital could demonstrate payment of the nonhospital site training program costs using journal entries that expense these costs in the hospital's GME cost center and credit the nonhospital site.)"

The Q and A Document provides no rationale supporting the Agency's position. We can think of no reason as to why this solely administrative burden (requiring the hospital to essentially pay itself) is placed on hospitals in these situations. We urge CMS in the final rule to explicitly allow these teaching hospitals to not specify the supervisory costs in the written agreement because the teaching hospital either owns the nonhospital site or both institutions are owned by the same organization.

H. Teaching Hospitals With Resident Counts Greater Than Their Resident Caps

A significant number of teaching hospitals have resident counts that are more than their Medicare resident caps. In previous discussions, CMS has stated that these hospitals can choose to not comply with the nonhospital site regulations since these FTEs would not be reimbursed regardless because of the hospitals' cap situations. The caveat is that the hospital would want to make sure that the number of resident FTE counts that it would forego is equal to or less than the number by which the hospital is over its cap. For example, if the nonhospital resident FTE count is five and the hospital's overall resident count (including the five nonhospital site resident FTEs) is five or more over its cap, the hospital need not comply with the nonhospital site requirements.

We would like CMS to confirm this understanding in the final rule. We also would like confirmation as to how hospitals that choose this option should complete their cost reports. We believe it makes most sense to have hospitals include these resident FTE counts on their cost reports. In this way, in the event that Congress would make a change regarding the resident caps, the cost reports would reflect an accurate count of the total number of residents for which the hospital is paying the residents' stipends and benefits.

I. Other Issues

Salaries versus Stipends—Given that residency training is the final educational step before a resident is capable of independent practice, the AAMC considers them to be students, not employees. Consequently, we urge CMS in the final rule to use the term "resident stipends" rather than "resident salaries."

Effective Date—Ever since the nonhospital site regulations were modified in 1998, there has been confusion and ambiguity regarding compliance issues. While attempting to provide clarity, the 2005 Q and A Document resulted in more ambiguity. Hospitals were frustrated because the 2005 document seemingly required them to obtain actual physician salary data yet supervising physicians understandably often refused such requests.

The history of this policy necessitates that the rule must be effective retroactively. Fairness and equity dictate such a result.

CONCLUSION

Thank you for this opportunity to present our views. We would be happy to work with CMS on any of the issues discussed above or other topics that involve the academic health care community.

If you have questions concerning these comments, please do not hesitate to contact me or Karen Fisher, Senior Associate Vice President. We may be reached at (202) 828-0490, or rdickler@aamc.org and kfisher@aamc.org.

Sincerely,

Robert M. Dickler
Senior Vice President
Division of Health Care Affairs

cc: Karen Fisher, AAMC

Table 1

Comparison of Coverage between the AMGA and the AAMC Compensation Surveys

Selected Specialty[1]	Physicians in the US[2]	AMGA 2006 Medical Group Compensation and Financial Survey		AAMC 2005-2006 Report on Medical School Faculty Salaries[3]	
		# of Physicians	% of Total Physicians	# of Physicians	% of Total Physicians
Primary Care					
Family Medicine	86,563	3,650	4.2%	2,361	2.7%
Internal Medicine	99,770	4,169	4.2%	3,604	3.6%
OB/GYN	40,356	1,389	3.4%	1,237	3.1%
Specialties					
Cardiology	21,721	574	2.6%	2,303	10.6%
General Surgery	28,028	871	3.1%	1,997	7.1%
Anesthesiology	38,771	1,121	2.9%	3,516	9.1%
Dermatology	9,868	508	5.2%	682	6.9%
Geriatric Medicine	2,676	74	2.8%	437	16.3%
Neurosurgery	4,836	220	4.5%	809	16.7%
Endocrinology	4,911	315	6.4%	875	17.8%
Rheumatology	4,157	289	7.0%	548	13.2%
Thoracic Surgery	4,906	201	4.1%	633	12.9%
Gastroenterology	11,353	765	6.7%	1,245	11.0%
Nephrology	6,631	350	5.3%	1,014	15.3%
Total for all specialties[4]	**730,575**	**34,897**	4.8%	**56,620**	7.8%

[1] Note that the AMGA and AAMC surveys have slightly different definitions for the specialties.
[2] Specialty is the primary specialty as reported among full-time active physicians in AMA 2005 Masterfile.
[3] Information for MD or equivalent full-time faculty who work in clinical science departments.
[4] Because only selected specialties are reported, the sum of the specialty counts will not match the total for all specialties.

Table 2

AAMC Faculty Salary Survey, 2005-2006

Total Compensation for M.D. or Equivalent Faculty
Instructors, Assistant Professors, Associate Professors,
Professors, Chiefs, and Chairs Combined, Selected Specialities
All Medical Schools

Department	Median	Mean
Cardiology-Med.	$231,000	$255,900
Dermatology	$226,000	$279,300
Endocrinology-Med.	$154,000	$165,600
Family Practice	$146,000	$153,800
General Internal Medicine	$145,000	$157,500
General Surgery	$253,000	$279,900
Geriatrics-Med.	$141,000	$152,500
Nephrology-Med.	$170,000	$180,100
Neurosurgery	$377,000	$427,500
OB/GYN: General	$201,000	$223,800
Thoracic & Cardiovascular Surgery	$351,000	$417,900

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March 26, 2007

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Centers for Medicare & Medicaid Services
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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.

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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

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.

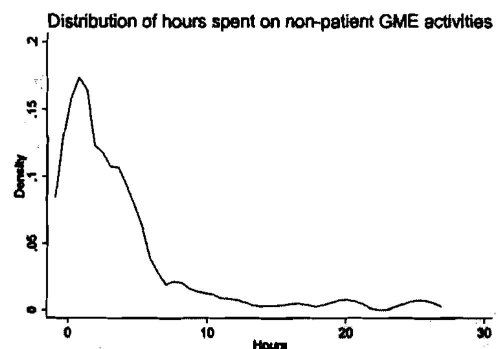
Table 2

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.

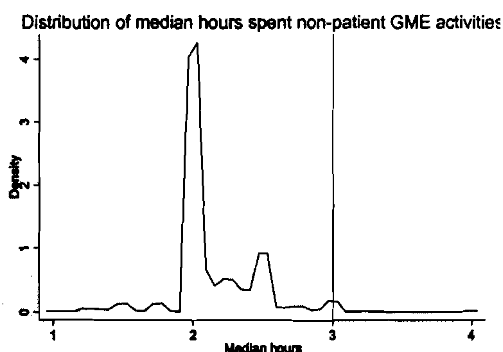
First, a univariate analysis of the results from bootstrap resampling, reported below in Table 3, shows that the 95% confidence interval of the median does not include 3. Indeed, it is very unlikely that 3 would ever be the estimated median number of hours per week spent on non-patient related GME.

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, 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

AAMC

Addendum A

EXAMPLE CALCULATIONS OF THE 90 PERCENT THRESHOLD

Overall Assumptions:

Resident's annual stipends plus benefits = $60,000
Supervising Physician annual salary = $ 170,000
Nonhospital site hours = 50
Resident-to-teaching physician ratio = 1:1
The 3 hour per week teaching physician presumption

Example 1—The resident spends 6 consecutive months at the nonhospital site:

CMS Assumptions:

1. The resident's annual stipends and benefits are prorated by ½ = $30,000
2. The supervision physician's annual salary is prorated by 1/2 = $85,000

Calculation:

Step 1) Calculate the portion of the teaching physician's salary associated with teaching activities:

($85,000) * (3 didactic hours/50 nonhospital site hours) = $5,100

Step 2) Calculate 90% of the total training costs at the nonhospital site:

90% (Resident's stipend plus benefits PLUS supervising teaching costs)
90% ($30,000 + $5,100) = $31,590 = 90% Threshold

Step 3) Subtract the resident's stipend plus fringe benefits from the 90% Threshold

$31,590 - $30,000 = **$1,590**

Result: For the 6 month consecutive rotation, the hospital would need to pay the nonhospital site $1,590

Example 2—The resident spends 2 and ½ days per week at the nonhospital site for a full year (aggregate= 6 consecutive months):

CMS Assumptions:

1. The resident's annual stipends and benefits are prorated by ½ = $30,000
2. The supervision physician's annual salary is NOT prorated = $170,000

Calculation:

Step 1) Calculate the portion of the teaching physician's salary associated with teaching activities:

($170,000) * (3 didactic hours/50 nonhospital site hours) = $10,200

Step 2) Calculate 90% of the total training costs at the nonhospital site:

90% (Resident's stipend plus benefits PLUS supervising teaching costs)
90% ($30,000 + $10,200) = **$36,180** = 90% Threshold

Step 3) Subtract the resident's stipend plus fringe benefits from the 90% Threshold

$36,180 - $30,000 = **$6,180**

Result: For the 2 and ½ day per week rotation that lasts a year, the hospital would need to pay the nonhospital site **$6,180.**

Summary—The hospital pays more for rotations that are less than a week than it would if the resident is at the nonhospital site full time for either 6 months or even a year. Note that the shorter the time spent at the nonhospital site (in terms of days per week) the more the hospital would have to pay because the supervising costs would not change, but the hospital's cost for residents' stipends and benefits would decrease.

By contrast, prorating both the resident stipends and physician salaries would result in the same supervisory cost calculation for both examples above. Alternatively, the three hour supervision time proxy could be prorated rather than the physician salary—it also would yield the same result.

Example 3— The resident spends five ½ day rotations at five different nonhospital sites for the year. (Aggregate nonhospital time = 6 months)[1] (For simplicity, this example assumes the same annual salary for the supervising physician at all five sites.)

CMS Assumptions:

[1] While we are confident that examples one and two reflect CMS's position, we have not confirmed example three with the staff.

1. For each of the five nonhospital sites, The resident's annual stipends are multiplied by 10 percent since the resident is spending 10 percent of their annual time at that site = $6,000 (The aggregate for all 5 sites is $30,00 which corresponds to the aggregate nonhospital site training time of 6 months)

2. For each site, the supervision physician's annual salary is NOT prorated = $170,000

For each of the five nonhospital sites, the supervisory cost calculation is:

Step 1) Calculate the portion of the teaching physician's salary associated with teaching activities:

($170,000) * (3 didactic hours/50 nonhospital site hours) = $10,200

Step 2) Calculate 90% of the total training costs at the nonhospital site:

90% (Resident's stipend plus benefits PLUS supervising teaching costs)
90% ($6,000 + $10,200) = **$14,580** = 90% Threshold

Step 3) Subtract the resident's stipend plus fringe benefits from the 90% Threshold

$14,580 - $6,000 = **$8,580**

Summary: The hospital would have to pay each site $8,580 with the sum total for all five sites being **$42, 900**.

If instead, the physician salary at each site was prorated to match the resident prorated salary (i.e, 10 percent of the total salary or $17,000) the calculation for each of the five nonhospital sites, the supervisory cost calculation is:

Step 1) Calculate the portion of the teaching physician's salary associated with teaching activities:

($17,000) * (3 didactic hours/50 nonhospital site hours) = $1,020

Step 2) Calculate 90% of the total training costs at the nonhospital site:

90% (Resident's stipend plus benefits PLUS supervising teaching costs)
90% ($6,000 + $1020) = **$6,318** = 90% Threshold

Step 3) Subtract the resident's stipend plus fringe benefits from the 90% Threshold

$6,318 - $6,000 = **$318**

Summary: The hospital would have to pay each site $318 with the sum total for all five sites being **$1,590**. This is the same amount that would be paid if the resident spent six months at one nonhospital site. Note also that the same result would occur if instead of prorating the physician salary, the supervision time proxy was prorated (ten percent of 3 hours or 0.3 hours).

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March 26, 2007

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CMS-1529-P
PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION

Dear Ms. Norwalk,

On behalf of the five family medicine organizations, we appreciate the opportunity to respond to the February 1, 2007 proposed rule 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, specifically with respect to proposed hospital direct and indirect graduate medical education policy changes.

We have been somewhat encouraged over the past several years to see signs that CMS has been striving to address some of the more onerous conditions it has imposed through regulation on the ability of residency programs to train residents in the community setting. As you know, through the Balanced Budget Act of 1997 (BBA), Congress mandated that training in the non-hospital setting should be counted for purposes of Direct and Indirect Graduate Medical Education (GME) under Medicare. We have struggled for many years now with the manner in which this mandate has been implemented through regulation, especially in view of the clear and explicit congressional intent to foster and encourage training in non-hospital settings. In addition this new proposal rises to new heights of complexity. We were disappointed that in light of such complexity that our three separate requests (since the proposed rule was published) for CMS to hold an, "Open Door Forum," dedicated solely to the GME provisions of this proposed rule were not honored.

Definition of "All or Substantially All": Historically, when only Direct GME was allowed to be reimbursed for the time residents spent training in the non-hospital setting, CMS (then Health Care Financing Administration (HCFA)) defined "all or substantially all" the costs of

training to include "the residents' compensation for the time spent at the non-provider setting." After the BBA, in implementing regulations published in July, 1998, CMS (then HCFA) re-defined "all or substantially all" to mean not only residents' compensation, but "residents' salaries and fringe benefits (including travel and lodging where applicable), and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct GME."

We continue to believe there is no need for that re-definition. More importantly, that interpretation is incorrect. Congress has not required a redefinition, and it has been the reason programs and hospitals have had years of difficulty complying with the regulations. Every regulation since then, along with audit requirements that were not included in regulation, has mired program directors and hospital administrators in increasingly onerous documentation and paperwork burdens. The documentation requirements have caused a great deal of training time to be discounted for GME reimbursement due to minute details that bear no relationship to the content and circumstance of the training. For example, while regulations have stipulated that written agreements must be signed before the training begins in the non-hospital site, it turns out for audit purposes, not only must the letter be dated prior to the beginning of such training, but the signature of the preceptor in that site must also be separately dated. These onerous conditions, and the commensurate loss of GME funds due to imprecise compliance, have wreaked havoc on the ability of residency programs and hospitals to provide the best education possible for the nation's physicians in training and contributed to the loss of millions in GME reimbursement.

Teaching costs in non-hospital settings were not included in the establishment of the reimbursement rates for GME. In regulations implementing the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, CMS developed a payment methodology for direct GME costs that described allowable costs. The base period for the determination of a per-resident amount (PRA) was for cost reporting periods beginning in FY1984. Didactic teaching time, or time spent on non-patient specific activities, was not included in those allowable costs. In an August 2006 final rule regarding prospective payment CMS reiterated very clearly that didactic time cannot be counted in the cost report. <u>It is ironic -- and clearly unreasonable – that CMS would require that the costs of teaching in those sites be paid, when the accrual of such costs is not allowed.</u>

For all of these reasons, we strongly urge that CMS to re-write the definition of "all or substantially all" for both Direct and Indirect GME, so that it is the same as it was prior to 1998, when Direct GME was able to be reimbursed in the non-hospital setting without these difficult and unreasonable bureaucratic hurdles. A revised definition would be more consistent with the congressional intent (see section on Legislative Intent, below) to encourage training of physicians in non-hospital settings.

We appreciate that CMS has established a definition of "all or substantially all" that for the first time acknowledges that "substantially all" has never been defined, and that to date "all or substantially all" meant "all." We welcome the positive step of setting of a threshold for "substantially all." It is our firm belief however that 90% is too high a

threshold for programs/hospitals[1] to meet. We would like to see a much lower threshold of 75%.

In contrast to the claim in the proposed rule that "industry representatives" define "substantially all" as being 90% or greater, to our knowledge none of the key organizations involved in this issue have recommended such a standard. To be fair, the community did raise the question of preceptors attesting to 90% of their time being spent with the residents in patient care, (see below) but we are unaware of any stakeholder group that has recommended "substantially all" be defined as 90% of costs in the non-hospital setting. In actuality, in our discussions with CMS, Agency staff at first proposed a threshold of 95%; the community did its best to negotiate that downward, and was only successful in reducing the amount to 90%. It was never our recommendation that the *best policy* would be that it be set at 90%. In fact, in October 2006, in a conference call with then CMS Administrator Mark McClellan, MD, PhD, on his last day in office, the family medicine community declined to support the proposal outlined in this rule and stipulated that we would respond with comments addressing our concerns should this be included in rulemaking. We also stated we would reserve the right to go to seek legislative remedy from Congress should CMS be unwilling to resolve the situation in a manner consistent with promoting the best education of future physicians and in keeping with Congressional intent outlined in the BBA.

It is interesting and revealing to note that in a closely related regulation, CMS has defined "substantially all" as 75 %. In the commonly termed "Stark Rule" regarding financial relationships, 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).

Since CMS has interpreted this language in one way under the Social Security Act for the Medicare program, it is not reasonable or defensible to define it differently under the same program. CMS has already interpreted "substantially all" in the context of Medicare as meaning 75 %. The issues under consideration in the Stark rule and here in the payment of costs in the non-hospital setting are very similar: both laws focus on physician practices. In the non-hospital site statute, Congress refers to the costs of a *physician practice*; in the Stark law, Congress refers to the services of a *physician*

[1] Although we recognize that according to the statute it is the hospital that must meet these requirements, much of the burden of complying with the regulations falls on the residency program itself, on behalf of the hospital.

practice. We see no valid reason for CMS to interpret the term "substantially all" differently in the non-hospital site context than they do for the Stark provisions.

In addition, courts have also defined "substantially all" as being 75% 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% of its total assets was a sale of "substantially all" of its assets. 199 A.2d 557, 562 (1964).

With this background of a previously codified interpretation by CMS, as well as courts' interpretations each designating the term "substantially all" to mean 75% or greater, 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%.

The proposed rule also recognizes that proxies should be allowed for certain information relating to achieving "all or substantially all" that is either difficult and/or costly to obtain. The proposal allows for proxies for the physician salary information, didactic training time, and physician work. In addition, the proposal allows the use of proxies for some or all portions, leaving it up to the program/hospital to decide what the most reasonable choice would be for their unique situation. We support the use of such proxies.

We also commend the agency for attempting to provide a way to allow programs/hospitals which were unable to achieve the overly burdensome requirements in regulation to date, to at least know if, and how much, they would have to pay each preceptor in a non-hospital site. This clarity as to the actual costs a program/hospital is obligated to pay is long overdue, and we appreciate its inclusion in the proposed rule.

Physician Attestation: During the summer of 2006, in response to the method proposed by CMS to calculate GME payments made to hospitals for the time that residents spend in non-hospital settings, we proposed, along with the American Osteopathic Association and the Association of American Medical Colleges, a simple form for teaching physicians to submit that would allow them to attest that they have spent at least 90 percent of their time devoted to training residents in patient care (i.e., non-GME related) activities. Since the hospital would have stipulated to paying all of the costs of the resident (i.e., salary and benefits) while in training, the physician's attestation would account for "substantially all" of the remainder of the costs based on the physicians' time.

This would seem to comply with the letter, dated June 2, 2006, to the Board Chair of AAFP from Herb Kuhn, then Director of the Center for Medicare Management. In that letter, the Director stated that the costs of training a resident in a non-hospital setting "are determined based on *the percentage of time* that the teaching physician spends in GME activities..." [Emphasis added]. If the physician can attest that the percentage of

time in GME activities is only 10 percent or less, then the test of a hospital incurring "all or substantially all" of the costs of training the resident should be met.[2]

CMS rejected this approach to resolving the disagreement about teaching costs at non-hospital sites with a vague statement about believing that a physician's *time* does not account for the *costs* of the training at the non-hospital site. Thus, CMS seems to be contradicting the clear assertion made by Director Kuhn that the costs are determined by the percentage of the teaching physician's time. We continue to believe that it is still a valid and appropriate way to account for the costs that hospitals actually incur in teaching residents.

Legislative Intent: The proposed rule characterizes a version of legislative history surrounding the BBA that is inaccurate. For example, in the proposal CMS states that "we believe the statute has set a priority to move resources, in terms of both residents **and funding**, (emphasis added) out into community settings." Contradicting that viewpoint is the report language accompanying the BBA, which states, "The conference agreement includes new permission for hospitals to rotate residents through non-hospital settings, which include primarily ambulatory care settings, **without reduction in indirect medical education funds.**" (Emphasis added)

In addition, in at least three separate places in the GME section of the Conference Report to the BBA, Congress states that the Secretary, in establishing rules to implement the statute is required to **"give special consideration to facilities that meet the needs of underserved rural areas."** (See conference report pages for the actual cites, on pages 817, 821, 822 (slightly different language about programs rather than facilities in the last cite.))

We have seen no attempt on the part of CMS to provide such special consideration. No incentives to encourage training in these sites have ever been included in regulation. We see no valid reason for CMS to object to the ability of physicians to volunteer their time or teaching services. We propose that there are at least three ways that CMS could encourage such training. CMS could: 1) allow for physician volunteerism, 2) allow programs/hospitals to exclude the costs of teaching physicians in the non-hospital setting as part of the definition of all or substantially all, and 3) decrease the threshold from 90% to 75% for hospitals to meet the "substantially all" definition. These three ways need not be considered mutually exclusive; adopting all three would be consistent congressional intent in providing the special consideration mentioned above.

Solo versus Group Practice Exception: The proposal discusses the difference between a solo practice and a group practice in terms of compensation and what services are provided to achieve that compensation. While we appreciate the argument

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[2] Early in 2006, CMS originally proposed that the threshold for physician time with the resident in patient care should be an impossible standard of 95 %. We agreed to discuss how to document meeting a less burdensome standard of 90 %. However, as we make clear in our comments, the 90 % threshold is inconsistent with the 75 % standard articulated in Medicare law for other tests of "all or substantially all."

on behalf of solo practices that explains why solo practitioners are exempt from these payment requirements, we have difficulty understanding CMS's extension of this logic so that group practices where compensation is not based on teaching cannot be exempt. For example, on page 4821 of the proposed rule, CMS states that, in the case of the group practice or clinic setting,..."this predetermined payment amount reflects all of his or her responsibilities at the non-hospital site, including treating patients, training residents, and other administrative activities (as applicable),..."the predetermined amount implicitly also compensates the physician for supervising residents." Yet on page 4825, in its discussion of multiple teaching physicians and the ratio of resident to teaching physician, CMS allows that "it may be that in fact only some of the physicians actually supervise the residents, while other physicians are not involved in the training program at all. The hospital may wish to document that only certain physicians are involved in the training program (in order to more accurately represent the structure and costs of the training program...)

We question how the predetermined compensation amount can implicitly compensate for teaching/supervisory activities, yet the hospital can document that some physicians are not involved in training at all. We believe, as we have stated to CMS many times in recent years, that a physician in a group practice should be able to attest that his or her compensation is not determined by, or based on, teaching activities, and in such cases the physician or group is in an indistinguishable situation to that of a solo practice physician and therefore should be exempt from the payment of teaching costs that they have not incurred.

Determining Costs*:* We continue to believe that CMS cannot and should not attribute costs to the supervisory physician training residents in the non-hospital setting for at least three reasons. First, if such physicians wish to volunteer their time, they should be allowed to do so – meaning there are no costs. Second, the norm as we understand it, among community preceptors is that patient schedules are not changed when a resident is present in their practice. In fact, for PGY2 and PGY3 residents, many preceptors schedule more patients because of the added benefit of having the residents present and helping with the caseload. So, in fact, again in this situation, there are no costs, and, in fact, there may be a financial benefit. Third, didactic training time (see earlier discussion) is not included in allowable costs of training, so there should be no need to pay for those non-allowable costs.

Issues specific to the proposed formula: We would like to comment on each of the three areas included in the formula: 1) National Average Physician Salary Data by Specialty, 2) Residents' salaries and fringe benefits, and 3) Number of hours spent in non-patient care GME activities in a Week and the number of Hours that the non-hospital site is open in a week.

National Average Physician Salary Data by Specialty: The proposal recommends using the American Medical Group Association (AMGA) salary information. Having searched many databases for salary information, we find the AMGA salary information to be higher than most other physician salary databases. As this would have the effect of

increasing the amount hospitals would have to pay to the teaching physicians, we would recommend against using this data source.

We suggest that CMS look to its own programs for this data. Under the Medicare program, section 1887(a) (2) (B), CMS uses the reasonable compensation equivalent (RCEs) limits applied to physicians' services in the outpatient setting. We recommend that CMS use this data for the purpose of the formula contained in this proposed rule. It has the benefit of being readily accessible (through the Federal Register); it can be updated by CMS annually, even though it has not been to date; and it provides some variation along geographic lines based on population levels. Moreover, it is based on what Medicare deems a reasonable compensation, not what the private sector might bear. If CMS is unwilling to use the RCEs, we recommend they use the AAMC's faculty roster database, rather than the AMGA information contained in this rule.

CMS also requested comments on the question of whether to use mean salary data or median salary data. Since the mean is very sensitive to abnormal values, or outliers, we would recommend that CMS use median salary data (if the agency does not agree to use the Medicare RCEs). We are looking for what typical physicians in a specialty earn, not a measure that is strongly affected by atypical salaries.

Residents' salaries and fringe benefits: Since the proposal makes a clear distinction between overhead costs, which are not allowed, and fringe benefits, which are, we urge CMS to ensure that professional liability insurance premiums are explicitly categorized in the final rule as fringe benefits. These premiums are commonly paid as part of the compensation package a resident agrees to when signing his or her employment contract. Without explicit confirmation in the final rule that these costs should be considered fringe benefits, we see problems 2-3 years down the road when cost reports are audited. We would like to prevent such a problem at the outset.

Number of hours spent in non-patient care GME activities in a Week: We have several comments to make on this section of the formula. First, we strongly disagree with the use of 3 hours as a proxy for the amount of didactic teaching time a supervisory physician provides per week of training.

The proposed rule refers to the use of a 3 hour standard as a reasonable proxy based on data collected from surveys conducted by the Association of American Medical Colleges (AAMC), the American Osteopathic Association (AOA) and the Academic Family Medicine Advocacy Alliance (AFMAA) (four of the groups signing this letter.) In addition CMS used information compiled from its own informal surveys of teaching physicians. To the contrary, AAMC did not provide survey data regarding didactic time when we met with CMS in September of 2005. AAMC provided physician salary data at that time. The AOA provided some data and expressed concerns over the validity of its data at that time. Please refer to their comments on this proposed rule regarding the validity of their data. With respect to CMS's data collection, although we have asked, we have never seen the data CMS collected informally, in order to assess its validity. Clearly any data that CMS has informally collected and used as the basis for regulation

should be able to be assessed for validity by the public. AFMAA submitted its survey data with the following limitations raised:

> "There are over 400 family medicine residencies in the United States, most with an estimated average of about 100 community preceptors. This means that out of a ballpark estimate of 40,000 potential respondents, we received only 0.36 percent -- a figure which casts serious doubt regarding anyone's ability to use these results to make any national or regional determinations. We have not had enough time to validate the responses or perform more sophisticated cleanup or analyses. With the small sample size, it is unlikely that it is worth pursuing such additional work. If one looks at the range column in several of the tables, one can see that some respondents may not have understood the survey questions or possibly they were not the most representative respondent. For example, if one looks at question 4, Table 3A, it is clear that we have at least one respondent whose response indicates he only spent one half hour on average per week on direct patient care. Similarly, question number 6 indicates that at least one respondent spends on average 30 hours per week on administrative duties related to residents. Another (question 5) spends on average per week of 30 hours educating residents without direct patient contact. If one compares these answers to the median it is clear they are outliers. We suggest that many of these respondents were either not the target group -the community preceptor in the non-hospital setting - or they did not adequately understand the question."

In addition, under the methodology section, AFMAA described the indirect nature of the survey – we asked program directors to send it out to their preceptors and ask them to respond. Not only did we have a low response rate, but it was obvious from some of the responses that some program directors, or other program faculty, answered the survey themselves.

Thus, it is not clear to us why CMS is pursuing the use of such extremely flawed data. All anecdotal data that we have -- as well as a much better survey done in Maine (with a good response) -- show the didactic training time by non-hospital preceptors to be de minimus at best. Anecdotal evidence suggests that any amount of time over one hour per week is way out of line with actual circumstances. One program director wrote "we did time-motion studies for about 15 of our rotations about 6 months ago. We have yet to identify any attending or rotation that devotes 3 hours of teaching time [weekly]! This was a survey of our Rii [PGY2] and Riii [PGY3] residents who understood what we were looking for. They were fully aware that any "teaching" that occurred that was in an effort attached to a bill, which was not teaching time. Our residents reported anywhere from 30 minutes to 1 hour of clearly devoted didactic teaching time!" In addition, with the publication of the final rule on inpatient prospective payment in August 2006, it is clear that all didactic training that <u>may</u> have been occurring in non-hospital settings will be brought into the hospital in order not to lose GME funds.

While we appreciate the fact that actual data may be used, rather than proxy data, we hope that CMS will allow the use of local surveys and sampling techniques for obtaining actual data, rather then comprehensive time/motion studies developed by uninvolved parties. Those would be administratively burdensome, extremely expensive, and for most family medicine programs, undoable. Again, this is an area where CMS should be explicit in the final rule so that audits of cost reports 2-3 years down the road don't deny training time based on a program/hospital using data that CMS may consider inadequate.

Number of Hours that the non-hospital site is open in a week: The proposed rule has solicited other possible proxies in place of the one outlined in the rule. We do not believe that the proxy contained in the rule is a useful marker of physician's time as a measure of a physician's costs. If one were to substitute physician work hours (which can be found in *JAMA*. 2003; 290:1173-1178), one would see a lesser cost to the hospital (see examples below). In addition, there is a coherent logic behind using this proxy, rather than hours the clinic is open. Since the physician salary data is based on all income per annum, not just that income generated in the non-hospital setting, the corollary data CMS should use would be work hours the physician performs in all settings, not just the hours the clinic is open.

Examples: Use of physician work hours/week vs. use of hours clinic is open/week:

Specialty	Salary times 3/hours site is open	Result: Physician costs per week	Salary times 3/work hours by specialty	Result: Physician costs per week
Family Medicine	$178,336 *(3/40)	$13,375	$178,336* (3/52.5)	$10,191
Orthopedics	$409,518 *(3/40)	$30,714	$409,518 * (3/58)	$21,182
Urology	$349,811 * (3/40)	$26,236	$349,881*(3/60.5)	$17,346
Ophthalmology	$281,112*(3/40)	$21,083	$281,112* (3/47)	$17,943

Lastly, with respect to the use of the 3 hours didactic time divided by the hours the clinic is open, we have major concerns over the CMS stipulation that one cannot pro-rate the 3 hours based on the time the resident spends in a specific clinic or office situation. It seems unreasonable that the program must pay the full 3 hour proxy for the teaching attending regardless of time spent in the office while at the same time prorating the resident cost based on actual time in the physician's office. Either both should be prorated or neither. For example, the rule requires payment based on the 3 hour proxy for physician time regardless of whether a resident is assigned to the community physician for 2 days or 5 days per week. At the same time the resident cost is based on actual time spent with the community physician.

The family medicine training experience customarily sends residents to train in more than one site every week. The ACGME requirements for Family Medicine require continuity experience for residents in the Family Medicine Center (FMC) for several half days a week. No matter what rotation the resident is on, in the PGY2 and PGY3 years, the family medicine resident is spending part of each week at the FMC and the other part in various combinations of settings depending upon the rotation. Frequently, training rotations will have a resident not just at the FMC, but at several different physician offices during the same week. Attached is an appendix[3] that includes responses from program directors across the country to the question, "Does your program ever send one resident to multiple group-practice sites in any given week?"

This normative behavior is clearly at odds with the way the formula, as we understand it, works. If CMS requires that physician time (and consequently that portion of salary associated with the time) may only be pro-rated in week-long increments or longer, the financial impact on family medicine residencies will be enormous, as well as skewed. To show how this would work, we have attached an Excel spreadsheet that works through the formula based on the following week-long schedule of a program in South Carolina:

<u>PGY-2 SURGICAL SPECIALTIES- 2 months duration</u>

Monday AM __________ Ophthalmology
Tuesday AM __________ Urology
Wednesday AM/PM ________ ENT*
Thursday AM/PM _________ Urology
Friday AM _________ Ophthalmology
Monday PM & Tuesday PM ____ Family Medicine Center (FMC)

* I have substituted orthopedics for ENT in the spreadsheet as I couldn't find that specialty's salary info on the AGMA's list for 2006

The resident salary is the actual resident salary for PGY2 for that program, and we have included a 25% increase for fringe benefits. Based on this scenario, if one can not pro-rate the physicians' time (relating it to the amount of time the resident spends with him or her), the hospital would be responsible for paying three preceptors $1,027 for one week. This example assumes that the resident is going to the same ophthalmology office each time, and not two different ones -- which is possible -- and the same holds true for urology.

When one looks at the costs associated with physician work, if the time spent in the physician's office is allowed to be pro-rated, we find an entirely different story. The

[3] Emailed comments have been edited for grammar and spelling.

hospital would have no additional costs associated with payment of preceptors for that week's training.

One additional concern with the scenario above, not specifically related to the size of payments, is the problem of paying different preceptors for the same time worked. It is double-dipping in the reverse, and it can be much more than double payments. While the preceptor is receiving only one payment, the hospital is paying several times over for training costs incurred during the same time period. We strongly urge CMS to revise its position on requiring week-long blocks of physician time as we are confident the agency would not want to adopt a rule that embraces such an inherently fraudulent situation to be put in place.

Miscellaneous:

1:1 resident to teaching physician ratio: We appreciate the effort on the part of CMS to recognize that it is not the actual number of physicians within a group practice that teach that is the pertinent factor, but rather the FTE equivalent. This allows for the use of the 1:1 ratio of resident to physician within the non-hospital setting, and we support that position.

Effective Date: The proposed rule requests comments on the effective date of this rulemaking. We support the earlier effective date. We appreciate that at a minimum, clarity is needed as soon as possible for programs and hospitals. We hope that they will be able to comply better with this rule than the current state of regulation, and so it would be helpful to put in place the earliest effective date practical.

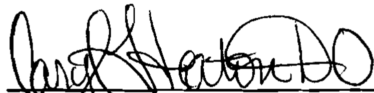
Administrative Burden: The proposed rule claims that "the administrative burden on hospitals related to calculating and documenting that they are paying for all or substantially all of the costs of residency training in nonhospital sites would be significantly reduced, if not eliminated, under our proposal." While it is true that the current regulatory situation is untenable, and many programs and hospitals do not have the resources, both technical and financial, to meet the current regulatory hurdle, this proposal would decrease only a portion of the burden.

For example, the paperwork burden required by this proposed rule is still massive. It requires complicated formulas to be followed for each resident at each site in the non-hospital setting. The amounts must then be included in each written agreement. For family medicine, with multiple rotations outside the hospital, including much of the PGY2 and PGY3 years (and even multiple sites within each week of training outside the hospital), identifying these costs and paying for them is still a tremendous burden on most family medicine programs – almost half of which are not located in major academic health center institutions, and so commonly lack the major staff resources a larger multi-specialty training institution may have. This disproportionately disadvantages family medicine and perhaps other primary care programs – with a devastating impact on rural access to care.

Hospitals over their cap on residency slots: CMS should explicitly state in the final rule if a hospital is over its cap on residency slots as determined by the BBA and the BBRA, (sufficiently to account for the time the residents are outside the hospital) it has no duty to fulfill the requirements of this rule as the Medicare program is not paying for such training.

Conclusion: We appreciate the time and effort CMS staff have put into this proposed rule, and their expressed intent to ease the burden on programs/hospitals in meeting the regulatory requirements CMS has previously set forth. However, the actions CMS has taken with respect to this issue over the past five years or more have created more confusion, more administrative burden, and more difficulty for programs and hospitals to achieve appropriate training in the non-hospital setting. We strongly believe that the fundamental basis for these regulations is significantly flawed. Moreover, this entire burden of regulatory compliance can be lifted by redefining "all or substantially all" the costs of training in the non-hospital setting to exclude teaching physician costs. Such a re-definition would meet the requirements of the statute (as it did prior to 1998), would meet the intent of the statute as evidenced in the report language cited above, and would increase the likelihood of training methods determined on the basis of what is in the best interests of educating better physicians, rather than on ways to maximize hospital payments.

Sincerely,



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Attachment # 15

Responses from the Association of Family Medicine Program Directors (AFMRD) listserv
March 1 - March 5, 2007

In response to the question: "Does your program ever send one resident to multiple group-practice sites in any given week?"

- We combine our ENT and Ophthalmology requirement into one rotation and the resident works in different practices in a given week. We did this to optimize the learning and exposure given the specialists' schedules.
- We do have a few rotations where there is a possibility of a resident going to more than one site during the same week.
- We have 5 longitudinal rotations (12 weeks each) such that for any given week the resident will spend 2 dedicated days at our office and 3 days at 2 or 3 different offices, some of which are group practices with individual billing, some are solos, and some are groups with salaries. All of the attendings practice out of our hospital as well and usually rounds with our residents in hospital are included in the day's work they share each week.
- We do that commonly. Also, we often send residents for very brief periods. For example, a resident might work with one private physician or at one private group practice one or two half days in a week and spend the rest of the time at the hospital or in the FPC.
- A quick response, it would be unusual for one of our residents to go to multiple group practices in a week. However, on the RRC required sports medicine rotation, the interns spend time at the outpatient orthopedics clinic, at a private sports medicine practice, and in the ski clinic in Park City. It does occur.
- This happens not infrequently at our residency.
- We have two rotations where we send one resident to at least three different groups a week.
- We have multiple rotations where residents work in multiple group practices in a week. For example we have an Ophthalmology/ENT month, Renal/GU month, and Ortho/Sports Med month. In each of the months the residents spend part of the time in our Family Medicine Center, and then split time in specialists' offices the rest of the time.
- This type of arrangement, i.e. multiple different group practices in a given week, is very common for us.
- We do that frequently
- We regularly send residents to multiple group practices every week.

- Our residents work on a fixed office schedule with the sessions scheduled the same day and time each week. Therefore when on a rotation a particular physician may not have office hours that match the residents' availability that week. So we send the resident to different groups. Also there are physicians within a group that do not teach. So residents are sent only during the times when the teaching physician has hours. They would then be rotated to another group on other days. There are also times when a physician has a day off so the resident is sent to another office.

- We have a number of rotations in our second and third year that have the residents go to several group practices within one week.

- Yes - when we have 3rd year electives we try send residents to 2 or 3 groups in one specialty over the course of a month. There are many examples when a week includes visits to two different group practices. We also have an occasional month where 2 subspecialties are done in the same week. If the dermatology specialist only has office hours 3 days a week and the ENT only has office hours 3 days a week we may have the resident spend 2 half days at one practice and 2 or 3 half days at the other.

- Yes we do - on pediatrics, ophthalmology, orthopedics, etc.

- Dermatology rotations include 3 different practices over 4 weeks. (VA clinic, one solo doc, and one group of dermatologists.) Outpatient psychiatry- 1 solo and 1 group practice psychiatrist over 6 weeks plus a substance abuse center. Geriatrics- several different nursing homes and hospices with different medical directors and supervising attendings -- which makes it too difficult to even figure out their practice arrangements and mechanisms of salary.

- Regarding resident rotating in multiple group-practice sites in any given week, we have been using this schedule for our Medical Specialties and Surgical Specialties rotations for PGY-2 and PGY-3 rotations.

- We also send 2nd and 3rd year residents to multiple private practices within a single week. It's common for us to get multiple sub-specialty experiences in a single month in this manner.

- This is SO bizarre that if you train residents for 2 1/2 days/week all year that means you have to pay $3000 more than if the resident is there 5 days a week for a full year. I guess CMS never heard of the straight face test???

- Like others you've heard from, we have a number of rotations (gynecology, urology, dermatology, orthopedics, and ENT/Ophthalmology - to name a few) which require the resident to go to more than one group practice site. Our institution has not seen the need and does not have the where-with-all to pay all of these non-hospital teachers for their contributions. They do it for the joy of teaching and the potential for future referrals. Our residency could not function and could not meet RRC requirements without the participation of these community physicians.

- Like many other program directors responding, we have several rotations during which residents rotate through different offices to maximize the learning experience within the schedule allotted.

- Yes. Assuming that what you want is to get a sense of the volume--we too have many PGY2 and PGY3 rotations where we send residents to multiple sites each week. Different practices, different specialties.

- We have numerous rotations where the residents go to different group practices in 1 month, sometimes in 1 week. These include split rotations (urology/ophthalmology) and 1 rotation with 2 different groups (orthopedics).

- We also have longitudinal rotations (like musculoskeletal medicine) where they may be in several different offices in the same week (orthopedics and sports medicine clinic for example).

- As you've seen from the list, these types of rotations are probably the norm rather than the exception.

- We often do our required surgical subspecialties all in the same week, which means we have an intern going to numerous different sub-specialists' office in the same week (urology, ophtholmology, ENT, etc).

- We have rotations with multiple preceptors during a week.

- How will the rest of you (or more accurately, your auditors in 2 - 3 years from now) interpret such rotations as surgery, cardiology, pulmonology in which the resident is assigned to an attending (not a hospital), but spends time in both the hospital as well as the attendings' office...is it a hospital based rotation..or an off-site rotation which has to follow these new rules??

- For our sports medicine rotation we have multiple providers that a resident may work with outside our own organization. They may work with an orthopedist group in the morning and a different physical therapy group in the afternoon, the next day work with yet another sports medicine physician half a day before going to continuity clinic. We are also in the process of switching to have more longitudinal experiences where sessions from a variety of rotations are mixed.

- We do this for out-patient surgery, gynecolgy, orthopedics, and sports medicine

- We do it frequently, and I suspect a lot of other programs due as it is difficult to arrange small blocks of what we call the "ologies" any other way. We do Orthopedics, ENT, diagnostic imaging, ophthalmology, and urology all in a 3 month block including most of those items in any one week.

- Ditto, we do this on ophthalmology, orthopedics, ENT, and urology.

- In our community hospital program, on the specialty rotations, the residents will often be with one practice one day, another practice another day. For example, on the orthopedic months, the residents will work with 3 different groups. On Pediatrics, they may be with 2 practices during the week

- We do during our PGY-2 community medicine month.

- *PGY-2 SURGICAL SPECIALTIES- 2 months duration
  Monday AM Ophthalmology
  Tuesday AM Urology
  Wednesday AM/PM ENT
  Thursday AM/PM Urology
  Friday AM Ophthalmology
  Continuity patients - Monday PM & Tuesday PM - Family Medicine Center

  PGY-2- MEDICAL SPECIALTIES, 3 months duration
  Monday AM/PM Gastroenterology
  Tuesday AM/PM Endocrinology
  Wednesday PM Rheumatology
  Thursday AM/PM Pulmonology (Output)
  Continuity clinic – Wednesday AM & Friday AM – Family Medicine Center

  PGY-3 MEDICAL SPECIALTIES II, 2 months duration
  Monday PM Nephrology
  Tuesday AM Hematology/Oncology
  Tuesday PM Infectious Disease
  Wed AM/PM Neurology
  Thursday PM Infectious Disease
  Continuity clinic – Monday AM, Thursday AM and Friday AM – Family Medicine Center

*Referenced in body of comments

Doctor's salary - opthalmology	$281,112	
Hours office open	40	
Resident salary	$44,928	
Plus 25% benefits	0.25	$56,160
Total cost in non-hospital setting	$77,243	
90% of total cost (substantially all)	$69,519	
extra amount to pay preceptor - yearly (90% of total cost - res stip and bene)	$13,359	one year's cost to opthamologist
extra amount to pay preceptor - weekly	$257	
Average Doctors Salary - urologist	$349,811	
Hours office open	40	
Resident salary	$44,928	
Plus 25% benefits	0.25	$56,160
Total cost in non-hospital setting	$82,396	
90% of total cost (substantially all)	$74,156	
extra amount to pay preceptor - yearly (90% of total cost - res stip and bene)	$17,996	one year's cost to urologist
extra amount to pay preceptor-weekly	$346	
Average Doctors Salary - ortho	$409,518	
Hours office open	40	
Resident salary	$44,928	
Plus 25% benefits	0.25	$56,160
Total cost in non-hospital setting	$86,874	
90% of total cost (substantially all)	$78,186	

Attachment #151-2

extra amount to pay preceptor - yearly (90% of total cost - res stip and bene)	$22,026	one year's cost to orthopedist
extra amount to pay preceptor - weekly	$424	
Family medicine continuity - no cost; salaried faculty	$0.00	
Total cost - one week	[illegible]	
Doctor's salary - opthalmology	$281,112	
Hours office open	40	
% of specialist salary based on time resident is in office	$1,081.00	
Resident salary	$44,928	
Plus 25% benefits	0.25	$56,160
% of resident salary and fringe based on time resident is in office	$216	
Total cost in non-hospital setting	$297	
90% of total cost (substantially all)	$267	
extra amount to pay preceptor - prorated by time within a week	$30	
Example if using pro-ration based on actual time spent in setting		
(not in increments less than a week)		
Doctor's salary - urology	$349,811	
Hours office open	40	
% of specialist salary based on time resident is in office	$2,018	
Resident salary	$44,928	
Plus 25% benefits	0.25	$56,160
% of resident salary and fringe based on time resident is in office	$324	
Total cost in non-hospital setting	$475	
90% of total cost (substantially all)	$428	

extra amount to pay preceptor - prorated by time within a week	$48	
Example if using pro-ration based on actual time spent in setting		
(not in increments less than a week)		
Doctor's salary - orthopedics	$409,518	
Hours office open	40	
% of specialist salary based on time resident is in office	$1,575	
Resident salary	$44,928	
Plus 25% benefits	0.25	$56,160
% of resident salary and fringe based on time resident is in office	$216	
Total cost in non-hospital setting	$334	
90% of total cost (substantially all)	$301	
extra amount to pay preceptor - prorated by time within a week	$33	
Family medicine continuity - no cost; salaried faculty	$0.00	
Total amount due to all [illegible] for one week [illegible]	[illegible]	negative amount = no cost to pay preceptors
[illegible]	[illegible]	

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MAR 26 2007

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 LTACHs. If anything, the data show the opposite, i.e., as the percentage of STACH discharges to LTACHs 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

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MAR - 6 2007

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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1111 Medical Center Blvd., Suite South 550 Marrero, LA 70072 504.349.2470 Fax 504.349.1287 www.rehabcare.com

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

beneficiaries, Medical Staff, and the facility 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 reject a regulation that will exacerbate the already deteriorating healthcare system in the Greater New Orleans area.

ALTERNATIVE I:

Only appropriate patients should receive care in the LTACH setting. We are fully supportive of the development of facility and patient criteria with QIO oversight to ensure that only appropriate patients are being treated by LTACHs. We ask that the expansion of the 25 Percent Rule be rejected and that facility and patient criteria be developed as a more appropriate alternative.

ALTERNATIVE II:

If the expansion of the 25 Percent Rule is enacted, at a minimum we request 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.

PROPOSAL:

The proposed rule includes a provision to change the short-stay outlier (SSO) rule to include that, if the patient stays for a period equal to the IPPS geometric length of stay plus one standard deviation, the payment would be equivalent to the IPPS payment.

ISSUE:

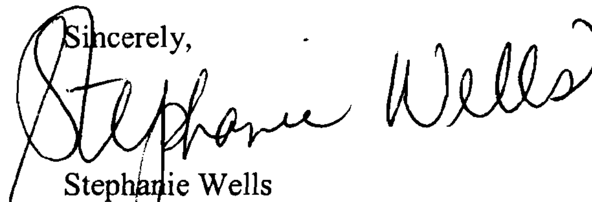
The SSO payment provision includes those patients that expire in that time frame as well. LTACHs treat some of the most critically ill and death can not usually be predicted. This provision could have an adverse impact on access to LTACH services for Medicare beneficiaries or place an unfair burden of compensation on LTACHs that provide care to those patients that expire.

ALTERNATIVE:

The proposed rule should state that, if the patient expires as a SSO patient, the facility will receive 100% of cost.

Your attention to this matter is greatly appreciated.

Sincerely,



Stephanie Wells
Administrator/CEO
Louisiana Specialty Hospital

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MAR 26 2007

March 26, 2007

BY HAND DELIVERY

The Honorable Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human 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; Comments to Proposed Expansion of the 25 Percent Rule, Section V.B., 72 Fed. Reg. 4776, 4809 (Feb. 1, 2007)

Dear Ms. Norwalk:

RehabCare, which owns and operates Louisiana Specialty Hospital, Marerro, Louisiana, St. Francis Specialty Hospital, Monroe, Louisiana, part of the St. Francis Health System, and Hendrick Long Term Acute Care Hospital, Abilene, Texas, part of the Hendrick Health System (collectively the "Hospitals"), appreciate this opportunity to submit these comments to the Centers for Medicare & Medicaid Services' ("CMS") proposed changes to the long-term care hospital ("LTCH") prospective payment system ("PPS"). RehabCare Group, Inc. is a New York Stock Exchange-listed healthcare services company headquartered in St. Louis, Missouri. RehabCare manages the delivery of rehabilitation therapy at 1,400 locations across the country. Among other hospital operations, the company owns 3 long–term acute care hospitals; one of which is located in New Orleans. RehabCare also operates approximately 40 other sites of rehabilitation therapy services in the Louisiana market. The Hospitals oppose the proposed expansion of the 25 percent rule on patient referral sources to include LTCH hospital-within-hospitals ("HwHs") that Congress in 1997 exempted from application of the HwH requirements ("Grandfathered LTCHs"). Each of the Hospitals is a Grandfathered LTCH. The Hospitals urge CMS to omit expansion of the 25 percent rule, including to Grandfathered LTCHs, in the LTCH PPS final rule and instead work with the Research Triangle Institute ("RTI") and the LTCH industry to develop and implement appropriate LTCH facility certification criteria and patient

admission criteria to ensure that LTCH payments are being made only to those providers that are administering medically complex care to severely ill patients. The Hospitals also urge CMS to initiate a standstill of the continued phase-in of the 25 percent rule.

I. Application of the Proposed Expanded 25 Percent Rule to the Grandfathered LTCHs Will Result in Loss of Patient Freedom of Choice, Massive Patient Relocation and Discontinuity in Patient Care, and Even Possible Closure of One or More of the Hospitals and Other Grandfathered LTCHs.

The current 25 percent rule provides that if an LTCH (or LTCH satellite facility) has a discharged Medicare inpatient population of whom more than 25 percent were admitted to the LTCH from a co-located hospital, payments for the patients admitted to the LTCH who cause the LTCH to exceed the 25 percent threshold are the lesser of the LTCH PPS payment amount or the amount that would be paid under the acute care inpatient PPS ("IPPS"). CMS proposes to expand application of the 25 percent rule from considering admissions from only co-located hospitals to all referring hospitals, and to subject LTCHs excepted by Congress in 1997 from the HwH requirements to the expanded rule. Application of the proposed expanded 25 percent rule to the Grandfathered LTCHs will result in loss of patient freedom of choice, massive patient relocation and discontinuity in patient care, and even possible closure of one or more of the Hospitals and other Grandfathered LTCHs.

In the Balanced Budget Act of 1997 ("BBA"), Congress excepted from the HwH requirements those LTCH HwHs that were classified as LTCHs as of September 30, 1995. Congress acted to protect these hospitals because it understood that they serve medically complex patients, often in low income, medically underserved areas; application of the HwH requirements to these hospitals would result in many no longer qualifying as LTCHs, forcing them to terminate operations and leaving their patients with few, if any, alternatives for appropriate long-term care. If CMS adopts the proposed expanded 25 percent rule and applies this rule to the Hospitals and other Grandfathered LTCHs, this policy will have the same effect as application of the HwH requirements would have had ten years ago against which Congress intervened to prevent–loss of patient freedom of choice, discontinuity in patient care, and likely closure of LTCHs.

Due to Hurricane Katrina, the New Orleans area is in a healthcare crisis. This crisis 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 wait times to be seen by emergency room personnel are greatly extended. It was documented that often these wait times are in excess of 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 cannot 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. 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".

Louisiana Specialty Hospital is a LTCH HwH in Marerro, Louisiana, part of the Greater New Orleans area, and shares a building with West Jefferson Medical Center. New Orleans is divided by the Mississippi River into what is called the "eastbank" and the "westbank." Greater New Orleans' residents seek health care treatment in their immediate community, whether the eastbank or westbank. Residents rarely cross the Mississippi River to seek treatment in the other community. Louisiana Specialty Hospital is located in the westbank. The two westbank short-term acute care hospitals are West Jefferson Medical Center and Ochsner Hospital's Westbank campus. The facility remained open during Hurricane Katrina and has remained committed to the citizens of New Orleans.

Physicians on the medical staff of Louisiana Specialty Hospital work very closely with West Jefferson Medical Center physicians to ensure that only patients who require the intensive level of care that LTCHs provide are considered for transfer and admission to Louisiana Specialty Hospital. The hospitals' medical staffs work together to provide these patients with a seamless transition from the short-term acute care setting to the long-term care setting. This symbiotic relationship also enables patients to remain on the westbank and close to family and friends.

If the proposed rule is implemented, Louisiana Specialty Hospital will attempt to remain a viable going concern, and in doing so will have no choice but to accept far fewer patients appropriate for LTCH-level care from West Jefferson Medical Center and attempt to admit appropriate patients from other facilities outside of the westbank. CMS's position that the 25 percent rule is a payment rule and not a certification rule and Louisiana Specialty Hospital would not be strictly prohibited from admitting more than 25 percent of its inpatients from West Jefferson Medical Center is academic in nature and ignores reality. The reality is application of the 25 percent rule to Louisiana Specialty Hospital would be devastating to the hospital and residents of the westbank. The present close working relationship of the medical staffs of West Jefferson Medical Center and Louisiana Specialty Hospital would be disrupted. Patient freedom of choice would be significantly reduced, as LTCH-level patients would be displaced from the westbank and forced to seek long-term care hospital care away from their families and friends. Continuity of care would be compromised, as patients' attending physicians often would not be able to follow the patients from westbank facilities to other health care facilities outside of the westbank. West Jefferson Medical Center would almost certainly be forced to retain in short-term acute care beds patients who are appropriate for LTCH care because of the unavailability of other appropriate healthcare facilities. Since Hurricane Katrina, the Greater New Orleans' area

has lost 51 percent of its hospital beds. The expanded 25 percent rule would only exacerbate the bed-shortage problem. Finally, there is significant concern that application of the expanded 25 percent rule to Louisiana Specialty Hospital could very well eventually force the facility's closure.

St. Francis Specialty Hospital and its patients would also be significantly negatively affected by the expanded 25 percent rule. St. Francis Specialty Hospital shares a building with St. Francis Medical Center. St. Francis Specialty Hospital serves medically complex patients and also operates pulmonary and ventilator clinical programs. Physicians on the hospital's medical staff treated 420 patients last year. If CMS would adopt the expanded 25 percent rule and apply it to St. Francis Specialty Hospital, the hospital would attempt to stave off closure by seeking patient admissions from non-host sources. Even if successful, patient freedom of choice would be restricted and continuity of care diminished as the closest LTCH furnishing the same type of long-term care services is 70 miles away.

Hendrick Long Term Acute Care Hospital shares a building with Hendrick Medical Center in Abilene, Texas. The nearest alternative LTCH is located 90 miles away in San Angelo, Texas. The expanded 25 percent rule would leave Hendrick Long Term Acute Care Hospital with no choice but to refuse many LTCH-level patient transfers from Hendrick Medical Center. Many of these patients would be relocated to distant LTCHs, far removed from their familial networks. The hardship this would create for patients and their families would be very significant. A patient's continuum of care would certainly be adversely affected. It would be necessary for patients to acquire a new attending physician in the distant community for continuation of their care. It could be problematic to identify an accepting physician and, for those successful, it would require a new patient-physician relationship be established. Families would be required to make burdensome sacrifices having to travel great distances to see their family members. Many would need to obtain temporary housing to be near their loved ones. The negative economic impact on patient families would be significant.

II. Application of the Proposed Expanded 25 Percent Rule to the Hospitals and Other Grandfathered LTCHs Would Be Contrary to Congressional Intent in Excepting Certain LTCHs From the HwH Requirements Because the Rule Would Eviscerate the Benefit of the Grandfather Protection, and the Proposed Rule is Not Supported by Credible Data.

In the BBA, Section 4417, Congress essentially exempted from the HwH regulatory requirements LTCH HwHs that were "classified" as an LTCH as of September 30, 1995. On October 1, 1997, the Health Care Financing Administration codified in the Medicare regulations this exemption from the HwH requirements for Grandfathered LTCHs.

CMS, by essentially recharacterizing the HwH performance of basic hospital functions requirement as the 25 percent rule, expanding the rule to apply to all LTCHs (not just co-located LTCHs), and subjecting Grandfathered LTCH HwHs to the rule, would be circumventing Congressional intent and sidestepping the HwH regulatory requirements. Inclusion of

the expanded 25 percent rule in the LTCH PPS regulations, rather than in the HwH regulations, would almost certainly result in a *de facto* change in the "classification" of at least some of the Grandfathered LTCHs to other provider types or even in their non-participation in the Medicare program. This is the same result as would have occurred if CMS had included the new rule in the HwH regulations and subjected Grandfathered LTCHs to the new rule. In effect, application of the expanded 25 percent rule to Grandfathered LTCHs would eviscerate the grandfather protection provided by Congress to these hospitals.

In addition, CMS proposes to apply the expanded 25 percent rule to Grandfathered LTCHs based on the assumption that LTCHs effectively serve as extensions or units of short-term acute care hospitals, such that patients do not receive a full episode of care at the short-term acute care hospital. However, CMS does not provide any empirical data or other credible evidence to support its assumption. Accordingly, extension of the 25 percent rule to Grandfathered LTCHs would fail the "rational basis" test that courts apply when reviewing agency rulemaking under the Administrative Procedure Act.

In summary, the proposed rule is: (1) inconsistent with Congressional intent to protect Grandfathered LTCHs from regulatory action that would jeopardize their continued operation as LTCHs; and (2) not supported by any empirical data or other credible evidence that LTCHs effectively serve as extensions or units of short–term acute care hospitals. Accordingly, the Hospitals will consider appropriate legal action if the rule is enacted as proposed.

III. The Hospitals Have Operated in Reasonable Reliance on CMS Statements That the Agency Will Not Apply the HwH Requirements to Them.

The Hospitals have operated for many years in reasonable reliance on CMS statements that the agency will not apply the HwH requirements to them. When in October 2004 CMS implemented the 25 percent rule, the agency properly did not apply the rule to Grandfathered LTCHs. CMS has failed to provide any empirical data supporting its proposal to effectively revoke their Congressionally-conferred grandfather status by applying the 25 percent rule to them.

In its LTCH PPS final rule (67 Fed. Reg. 55954 (Aug. 30, 2002)), in response to a question asking how Grandfathered LTCHs will be affected by the LTCH PPS, CMS stated as follows:

> We interpret Section 4417 of the BBA, codified as Section 1886(d)(1)(B) of the Act and implemented 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 care hospital inpatient prospective payment system. <u>The 'grandfathered' status conferred by the statute, which allowed these particular</u>

> 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. at 55969 (emphasis added).

In the FY 2003 IPPS final rule, CMS again explained the significance of the grandfathered status for the Grandfathered LTCHs:

> 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) 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-a-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 appropriate to limit the grandfather provision to those hospitals that continue to operate in the same manner as they had operated prior to the effective date of those rules. . . . We want to reiterate that, in establishing grandfather 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.

68 Fed. Reg. 45346, 45463 (Aug. 1, 2003) (emphasis added).

Importantly, in its FY 2005 IPPS final rule, CMS reiterated again that Grandfathered LTCHs are properly excluded from application of the HwH requirements. At the same time, for LTCHs CMS replaced the HwH performance of basic hospital functions requirement, which includes the alternative condition that no more than 25 percent of a HwH's inpatient population may originate from its host hospital, with the 25 percent rule. In doing so, the agency essentially recharacterized the rule as a special payment provision applicable to LTCH HwHs. Significantly, CMS properly did not subject Grandfathered LTCHs to the 25 percent rule but instead continued to honor the Congressional grandfather. CMS provides no support for its attempt now to reverse course and attempt to apply the 25 percent rule to Grandfathered LTCHs. Recharacterization of the 25 percent rule as a payment rule does not provide CMS with the equitable basis to act contrary to its previous public statements that the agency will not apply the HwH requirements to Grandfathered LTCHs, upon which statements the Hospitals have reasonably relied in developing and implementing their patient care policies.

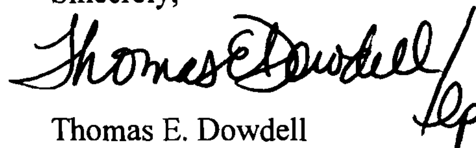
IV. The Hospitals Request That in the Final Rule CMS Reject Expansion of the 25 Percent Rule, Including to Grandfathered LTCHs, Initiate a Standstill of the Continued Phase-in of the 25 Percent Rule, and Work With the Research Triangle Institute and the LTCH Industry to Implement Appropriate LTCH Facility and Patient Admission Criteria.

For the reasons described above, the Hospitals request that in the LTCH PPS final rule CMS reconsider and reject expansion of the 25 percent rule, including to Grandfathered LTCHs. The proposed rule would jeopardize the continued operation of each of the Hospitals for reasons unrelated to patient care, as each is located in a community that does not have multiple other hospitals from which to obtain patient referrals of LTCH-level patients. Further, as described above, the proposed rule would penalize Medicare beneficiaries and their families, again for reasons unrelated to patient care. The Hospitals also ask that the agency initiate a standstill of the continued phase-in of the 25 percent rule. The Hospitals believe that the 25 percent rule, along with other proposed LTCH payment provisions such as paying LTCHs a reduced rate for short stay outlier ("SSO") cases despite the fact that CMS finalized a rule just last year that compensates LTCHs no greater than cost for SSO cases, are inconsistent with the Congressional mandate that the LTCH PPS account for the cost of care in hospitals that treat medically complex patients.

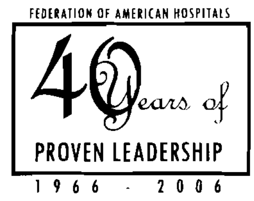
RTI identified in a December 2006 report feasible facility and patient admission criteria that would distinguish LTCHs from other acute care facilities. The Medicare Payment Advisory Commission ("MedPAC") made similar recommendations in June 2004. The Hospitals request that CMS reconsider the RTI report and MedPAC's recommendations and work with RTI and the LTCH industry to develop and implement LTCH facility criteria and patient admission criteria that would better ensure access for patients for whom LTCH care is medically appropriate. The Hospitals strongly believe that if a Medicare beneficiary requires the intensive level of care that LTCHs provide, it should not matter from which short-term acute care hospital the beneficiary is transferred.

The Hospitals appreciate this opportunity to express their concerns with the proposed policy of expanding the 25 percent rule to Grandfathered LTCHs.

Sincerely,



Thomas E. Dowdell



Charles N. Kahn III
President

March 26, 2007

VIA HAND DELIVERED

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Rm. 314G
Washington, DC 20201

Re: Comments to the Medicare Program: Prospective Payment System for Long-Term Acute Care Hospitals RY 2008; Proposed Annual Payment Rate Updates and Policy Changes; Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes
File Code: CMS-1529-P

Dear Ms. Norwalk:

This letter presents the comments and recommendations of the Federation of American Hospitals ("FAH") to certain aspects of (I) the proposed annual payment rate updates, policy changes and clarifications under the Prospective Payment System for Long Term Care Hospitals ("LTCH PPS") for rate year ("RY") 2008 (*see* pages 1-46), and (II) Payment for Direct Graduate Medical Education (*see* pages 46-+52), which were published by the Centers for Medicare and Medicaid Services ("CMS") in the Federal Register on February 1, 2007 (the "Proposed Rule").

The Federation of American Hospitals is the national representative of privately owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, short stay and long term care hospitals in urban and rural America, and provide a wide range of ambulatory, acute and post-acute services. The FAH appreciates the opportunity to comment on CMS' Proposed Rule regarding changes to the LTCH PPS for rate year 2008.

801 Pennsylvania Ave., NW, Suite 245 • Washington, DC 20004-2604 • 202-624-1500 • Fax: 202-737-6832

I. LTCH PPS ISSUES

A. Overview

FAH opposes many of the severe and arbitrary reductions in LTCH payments that will result if these proposed changes to the LTCH PPS are implemented. Particularly in the areas of extending the so-called "25% Rule" from co-located hospitals within hospitals ("HwHs") to all LTCHs, and further changes proposed to the short stay outlier ("SSO") reimbursement policy, the FAH believes that CMS has introduced various measures and payment principles that are impractical, conceptually deficient, and in some cases, contrary to Congressional mandates and/or a long history of regulatory consistency. In addition, many aspects of CMS' Proposed Rule continue to blur key distinctions that the Congress has specifically mandated between LTCHs and shorter stay general acute care hospitals, unfortunately contributing to a system where patients will likely find it more difficult in the future to receive their care in the most appropriate and beneficial type of facility.

Based on FAH's analysis, moreover, we believe that CMS has used flawed or incomplete data in many instances in developing its proposed changes to LTCH payments for RY 2008. FAH's analysis shows that many of the assumptions on which CMS has based its proposals are either inaccurate, unsupported by verifiable clinical data, or do not represent an objective measure of cost-savings across the many types of providers that ultimately will be impacted by this Rule, if adopted. FAH believes, therefore, that prior to finalizing these proposals, CMS should significantly and carefully revise several of its proposed changes in accordance with these comments. Specifically, FAH urges CMS to step back from several of its more aggressive changes and to allow the many changes that have already been incorporated into the LTCH PPS over the last couple of years to take effect more completely. Based on the FAH's analysis, once these prior changes work their way through the system, we believe that many of the current proposed changes will prove to be unnecessary, in addition to being unwarranted at this time.

FAH also recommends, in addition, that CMS reconsider its proposed changes to the LTCH PPS in light of the Medicare Payment Advisory Commission ("MedPAC") recommendations issued in June 2004 (and revised and/or commented upon several times since then) that the certification criteria for the Medicare LTCH provider category be strengthened to assure that LTCH payments are being made only to those providers which are administering medically complex care to severely ill patients. FAH notes further that the United States Congress is now considering two bills, reportedly with substantial bi-partisan support, H.R.562 and S.338, which would far 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 and the very specific direction offered today by H.R.562 and S.338, the FAH believes that the LTCH system of care would be far better served by restructuring the LTCH reimbursement and certification system in line with MedPAC's recommendations and Congress' bills, rather than by responding in almost a desperate fashion to address perceived reimbursement imbalances which, frankly, based on current data, may not exist anymore. FAH urges CMS, therefore, to avoid rash and likely unsupportable actions aimed at cutting payments, when what the LTCH system needs is more fundamental definition of what LTCH care is and should be, and a slower, more deliberate approach in structuring payment for LTCH services.

Apart from the more global view, however, FAH also believes that CMS is making significant mistakes in selected areas of this Proposed Rule. For example, extending the so-called "25% Rule" from hospitals within hospitals to freestanding LTCHs and previously grandfathered (under 42 C.F.R. § 412.22(f)) LTCH HwHs is completely unnecessary given the **current** state of the LTCH industry, appears to be contrary to an express statutory directive from Congress, and conflicts with a long line of regulatory interpretations of the grandfathering provisions applicable to LTCH HwHs. In addition, FAH notes that CMS' concerns regarding expansion of the numbers of freestanding LTCHs and/or allegedly inappropriate admissions from primary referral sources to freestanding LTCHs are seriously overblown and should be carefully reevaluated by CMS in light of the industry's comments. Adoption of the proposed changes to the 25% Rule will also undoubtedly interfere with patient choice and the effective and efficient practice of medicine, and will disrupt the continuity of care in countless communities across the country.

The FAH is also specifically concerned and asks CMS to reconsider carefully its proposed policy for further limiting payment for SSO cases. CMS continues to assume erroneously that all or close to all so-called "short stay" cases – even those whose stay exceeds the statutory threshold of 25 days to qualify as an LTCH – should never have been admitted to an LTCH and therefore should now be paid at a short stay inpatient PPS rate. The FAH believes that CMS has no justification for implementing such a policy where that policy will result in a rate that actually fails to cover a LTCH hospital's costs of providing treatment in the vast majority of, if not virtually all, SSO cases. The FAH contends that to the extent CMS is concerned about "inappropriate" or premature admissions to LTCHs, CMS should implement targeted non-payment related approaches to address its concerns, such as preadmission physician certifications, uniform admission screening criteria, and continued, extensive quality improvement organization ("QIO") reviews. CMS' new proposal on SSO reimbursement is not workable on a practical level and will result only in the reduction of LTCH care available for patients, which clearly is not the result intended by Congress in mandating LTCH PPS or in establishing LTCHs as a separate level of care.

Finally, FAH is deeply troubled by CMS' proposed offset of the market basket update of 3.2% for RY 2008 by an alleged "apparent" case mix increase of 2.49%, thereby reducing the actual market basket update applicable to LTCH providers reimbursement to 0.71%. As FAH discusses more specifically below, the FAH believes that this offset is unsupported by any verifiable data, contrary to the express requirements of existing regulation, and an attempt to minimize the impact of a validly calculated market basket update by incorporating into the market basket calculation a factor (case mix) that was never intended to be considered as a part of that market basket index. Again, the FAH will urge CMS to reconsider seriously its proposal to reduce so substantially the market basket update, and to recognize that case mix increases, whether real or "apparent", have been addressed more than adequately by other reimbursement changes already adopted and in effect.

The number of LTCH providers is no longer growing. Yet this Proposed Rule would impose what could be characterized as punitive payment cuts which will hurt both LTCH providers and Medicare beneficiaries alike. Aspects of the rule also interfere with patient choice and a physician's discretion to make important choices regarding the practice of medicine, both of which have always been fundamental principles of the Medicare program. The U.S. Congress

has repeatedly supported LTCH providers as an important source of care for medically complex patients who need long-term hospital stays; however, the Proposed Rule suggests that CMS disagrees with this premise.

In summary, the FAH strongly urges CMS to reconsider several key aspects of the Proposed Rule. Adoption of the rule as proposed will significantly hinder the ability of many LTCHs to continue to provide quality patient care to Medicare beneficiaries and result in arbitrary payment reductions that make it difficult for many existing LTCHs to continue providing appropriate care to Medicare beneficiaries who are projected to require such services. And if CMS determines that some or other of these changes are needed for some reason, FAH believes that such dramatic payment reductions must be based on considerably more solid data analysis and more eminently supportable conclusions. When carefully analyzed, many of the arguments and data proffered by CMS in support of the Proposed Rule simply cannot withstand reasonable scrutiny.

"OTHER PROPOSED POLICY CHANGES FOR THE 2008 LTCH PPS RATE YEAR"

B. Expansion of Special Payment Provisions for LTCH Hospitals Within Hospitals (HwHs) and LTCH Satellites: Proposed Expansion of the 25% Rule to Certain Situations Not Currently Covered Under Existing Section 412.524

1. CMS Proposal.

In the fiscal year ("FY") 2005 Inpatient Prospective Payment System ("IPPS") Final Rule, CMS established special payment provisions included at 42 C.F.R. § 412.534 for LTCHs that are HwHs and for satellites of LTCHs that are co-located with host hospitals. Apparently concerned about patient shifting between the host short-term acute hospitals and their co-located LTCH HwHs or satellites for financial reasons, CMS specified in the FY 2005 IPPS final rule that a payment adjustment would apply in the case of discharges from co-located LTCHs (including satellite LTCHs) to the extent the discharging LTCH or satellite derives in excess of 25% of its patients from the co-located host hospital in which the LTCH (or satellite LTCH) is located. CMS expressed its concern at that time that co-located LTCHs and satellites may be functioning as "units" of the host hospital with which the LTCH or satellite is co-located and that this should not be permitted without a payment limitation being placed on the discharging LTCH or satellite.

CMS also expressed its concern at that time that without such additional payment limitation, the "separateness and control criteria" established in 42 C.F.R. § 412.22(e)(i) through (iv) and the "performance of basic hospital functions" aspect of the separateness and control requirements, which were applicable to all HwHs, not just LTCH HwHs, were not adequate to assure that certain patients were not being prematurely discharged from the host hospital and then readmitted immediately thereafter to the co-located LTCH HwH or satellite. As a part of this payment limitation in 42 C.F.R. § 412.534, CMS also established that rural HwHs would not be subject to the payment limitation unless such rural providers admitted in excess of 50% of

their patients from the hospital in which the LTCH HwH or satellite was located. In addition, CMS established that LTCH HwHs and satellites which were co-located with a hospital that was the "dominant" hospital within a particular metropolitan statistical area ("MSA") would also be excused from the 25% requirement, and would be limited to obtaining the lesser of 50% of its admissions from that co-located dominant MSA hospital or to that percentage (between 25% and 50%) equal to the dominant MSA hospital's percentage of total discharges in the MSA during the prior fiscal year.

CMS also established a "transition period" for its payment rule whereby the limitations on reimbursement applicable to LTCH HwHs and satellites would not be applied in the first year of the transition (for cost reporting periods beginning on or after October 1, 2004 through September 30, 2005) but that the percentage of discharges admitted from the host hospital to the LTCH HwH or satellite could not exceed the percentage of discharges admitted from the host hospital to the LTCH HwH or LTCH satellite in its FY 2004 cost reporting period. Starting in the second year of the transition period, the payment limitation would apply and the co-located LTCH would be limited to admitting the lesser of the percentage of their discharges admitted from their host during the LTCH's FY 2004 cost reporting period or 75%. In the third year of the transition the LTCH HwH would be subject to the payment limitation to the extent its Medicare discharges admitted from the host exceeded the lesser of the percentage of its Medicare discharges admitted from its host during its FY 2004 cost reporting period or 50%. Finally, in the fourth year after adoption of the rule, LTCH HwHs and satellites would be subject to the full payment limitation with no more than 25% of an LTCH HwH's or satellite's patients being permitted to have been admitted following discharge from the host hospital (or other applicable percentage involving rural or dominant MSA hospitals as discussed above).

In fashioning this rule, CMS chose to exempt two types of LTCHs; first, freestanding LTCHs (*i.e.,* those not co-located with another hospital); and second, LTCH hospitals within hospitals that had previously been exempted from having to meet the "separateness and control" and "performance of basic functions" criteria stated in 42 C.F.R. § 412.22(e), as a result of the "grandfathering" exemption stated in 42 C.F.R. § 412.22(f). In exempting these two groups from the payment limitations established in 42 C.F.R. § 412.534, CMS recognized that freestanding LTCHs are not so geographically proximate to potential referring hospitals such that a freestanding LTCH would function as a "unit" of the referring hospital, and that previously grandfathered LTCH HwHs (pursuant to Section 412.22(f)) should, by virtue of their grandfathered status, not be subject to payment limitations that are so closely related to meeting the "separateness and control" and "performance of basic functions" criteria stated in Section 412.22(e).

The payment limitation, itself, to the extent it applies to any LTCH HwH discharge, requires that for those excess discharges in any given year, the LTCH HwH or satellite would receive only the lesser of the LTCH PPS amount for that discharge or an amount equivalent to the amount such a discharge would have been reimbursed under the IPPS had the patient been admitted to a short-term acute care hospital for the same condition and length-of-stay. In most, if

not virtually all cases, the amount payable under the IPPS would be less to substantially less than payment under the LTCH PPS.[1]

CMS now proposes to expand the payment limitation (in most cases, the "25% Rule") to freestanding LTCHs and to LTCH HwHs previously "grandfathered" out of compliance with the hospital within hospital separateness and control and performance of basic functions criteria under 42 C.F.R. § 412.22(f). In addition, CMS proposes to apply the 25% (or other applicable percentage for rural providers, dominant MSA providers and urban single providers) to each individual hospital referral source to the LTCH by site or campus, not by provider number.

Furthermore, CMS proposes to bring freestanding LTCHs and previously grandfathered LTCH HwHs and satellites under this payment exception within one year or less (depending on an individual LTCH's cost reporting year start date) so as to in effect eliminate any real transition period for these LTCH providers which were previously completely exempt from the rule. Thus, while co-located LTCH HwHs and satellites were granted a four-year transition period within which to adapt their patterns of admissions from and relationships with other providers, previously grandfathered LTCH HwHs and all freestanding LTCHs are being given virtually no transition period at all.

2. CMS' Proposal Is Based On Faulty Assumptions Regarding The Differences In Care Provided By Short-Term Acute Care Hospitals And Long-Term Acute Care Hospitals.

CMS' policy proposal appears to be based on assumptions that (i) all LTCHs effectively act as "extension sites" or "units" of short-term care acute hospitals and (ii) patients do not receive full episodes of care at a short-term acute care hospital before being admitted to a long-term acute care hospital. These assumptions are based upon conjecture, not data. Indeed, there are no data showing that the Medicare program is paying twice for the same episode of care with respect to LTCH admissions.

When Congress established long-term acute care hospitals as a separate category of hospitals under the Medicare program, Congress acknowledged that LTCHs are needed to treat a distinct type of patient: patients who typically are afflicted with extremely complex conditions that will require fairly intensive hospital care over much longer periods of time than would normally be admitted and treated at a short-term acute care hospital. Not surprisingly, therefore, there are no data to support the conclusion apparently reached by CMS that LTCH patients merely continue the same episode of care that began previously in a short-term acute care hospital. CMS' own contractor, the Research Triangle Institute ("RTI"), acknowledged as much in its recent RTI report, indicating that the issue is not well understood. RTI concluded that severity of illness and condition is an important predictor of LTCH use and that physicians associated with LTCHs believe that most LTCH patients have acute exacerbations of chronic respiratory conditions, multi-system organ failures, and other complications, including wounds

[1] For purposes of calculating the applicable percentage of admissions (usually 25%) in excess of which the payment limitation goes into effect, patients achieving outlier status at the discharging short-term care acute hospital are not counted toward the limiting percentage.

and infections, that often require very complex and long-term care, as opposed to the shorter term interventions and recovery times one normally would expect in a short-term acute care hospital.

For example, the available data show that, contrary to CMS' own example, DRG 475 patients in a short-term acute care hospital are predominantly discharged from an LTCH as DRG 483 (ventilator patient with tracheotomy) following the surgical implant of the trach in the short-term acute care hospital. Fundamentally, the admission to the LTCH is for a different episode of care.

CMS' conclusion relating to DRG 475 that after undergoing a tracheotomy procedure in a short-term acute care hospital, the patient is then subsequently admitted to a long-term care acute hospital for the same condition or treatment, is therefore fundamentally wrong. In fact, many patients who undergo tracheotomies in short-term acute hospitals are just that, short stay hospital patients, and these patients would never be referred for subsequent treatment to an LTCH. On the other hand, for those limited number of tracheotomy patients who need to stabilize a variety of associated conditions, such as systemic or incision site infections, extreme difficulty adapting to the trach equipment or other ventilator related problem, a stay in an LTCH may well be what is absolutely necessary to assure recovery and improvement to the extent necessary to be discharged entirely from an acute setting. In this sense, CMS is actually paying for the second episode of care as a distinct and separate episode, related to a much more medically complex situation than was contemplated during the first hospital stay at the short-term acute care hospital.

The Medicare program's own data substantiates that the vast majority of admissions to LTCHs from short-term acute hospitals involved patients who received a full episode of care at the short-term hospital, but who then required a subsequent follow-up and separate episode of care in a LTCH. There is no evidence that patients admitted to LTCHs from short-term acute hospitals experienced a shorter than normal or truncated course of treatment at the short-term acute facility. (*See* also Sections I.B.3 and I.B.4, *infra.*)

2005 MedPAR data shows that, among discharges from all short-term acute facilities (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. *See* Table 1 to comments submitted by Acute Long Term Hospital Association ("ALTHA") to Proposed Rule, March 23, 2007, attached as Exhibit 1 hereto. Together, discharges from short-term acute facilities that received a full payment accounted for a total of 78% of all short-term acute facilities' discharges. Similarly, 68% of short-term acute facilities' discharges to LTCHs (112,243) received the full payment without outlier payment and an additional 10% received both the full payment plus an outlier payment. *Id.* Together, discharges from short-term acute facilities to LTCHs that received a full payment accounted for a total of 78% of all discharges from a short-term acute facilities to an LTCH. The fact that the percentage of short-term acute facilities' discharges to LTCHs that received a full payment is substantially the same as for all discharges demonstrates that patients are receiving a full episode of care at the same rate regardless of a subsequent admission to a LTCH. This data contradicts the assumptions on which CMS bases the Proposed Rule.

3. Short-Term Acute Care Hospitals Are Not Discharging Patients To LTCHs "Early," Prior To Completing Episodes Of Care, To Maximize Profit.

The data do not support a contention that short-term acute care hospitals systematically discharge patients "early" to LTCHs prior to completion of an episode of care in order to maximize profit or obtain a full DRG payment. In fact, MedPAR 2005 data show that the average length of stay for acute hospital patients eventually sent to LTCHs is more than 4 days longer than the geometric mean length of stay for patients in the same DRGs. *See* Exhibit 5, Chart No. 8. Among non-trach patients, the average length of stay for patients eventually sent to LTCHs is nearly twice the geometric mean length of stay for all patients in the same DRGs. *See* Exhibit 5, Chart No. 9. This indicates that the more medically complex patients typically sent to LTCHs are actually staying in the acute hospital longer than the average patient and that acute hospitals do not systematically discharge patients to LTCHs early in order to maximize profits (or for that matter, for any other reason). 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. *See* Exhibit 5, Chart No. 7. However, as discussed more fully below (in Section B.4, at Chart No. 9, *infra*), payment for nearly 70% of these patients is lower than a full DRG amount because such 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 LTCHs are subject to the post acute payment policy; thus, any concern that CMS might have about "early discharge" of patients by acute care hospitals to LTCHs is already addressed by CMS payment policy. In any event, there is no evidence from the data that "early discharge" is occurring.

4. Short-Term Acute Care Hospitals Do Not Discharge Patients To LTCHs "Early," Prior To Completing Episodes Of Care, To Avoid High Cost Outlier Status.

Although not specifically discussed in the rulemaking record, it has been suggested that another possible justification for the proposal to extend the 25% rule to freestanding LTCHs is the concern that short-term acute providers may be discharging patients "early" to LTCHs, prior to completing episodes of care, to avoid high cost outlier status. CMS has not published data to support this concern. 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 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, even if 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.

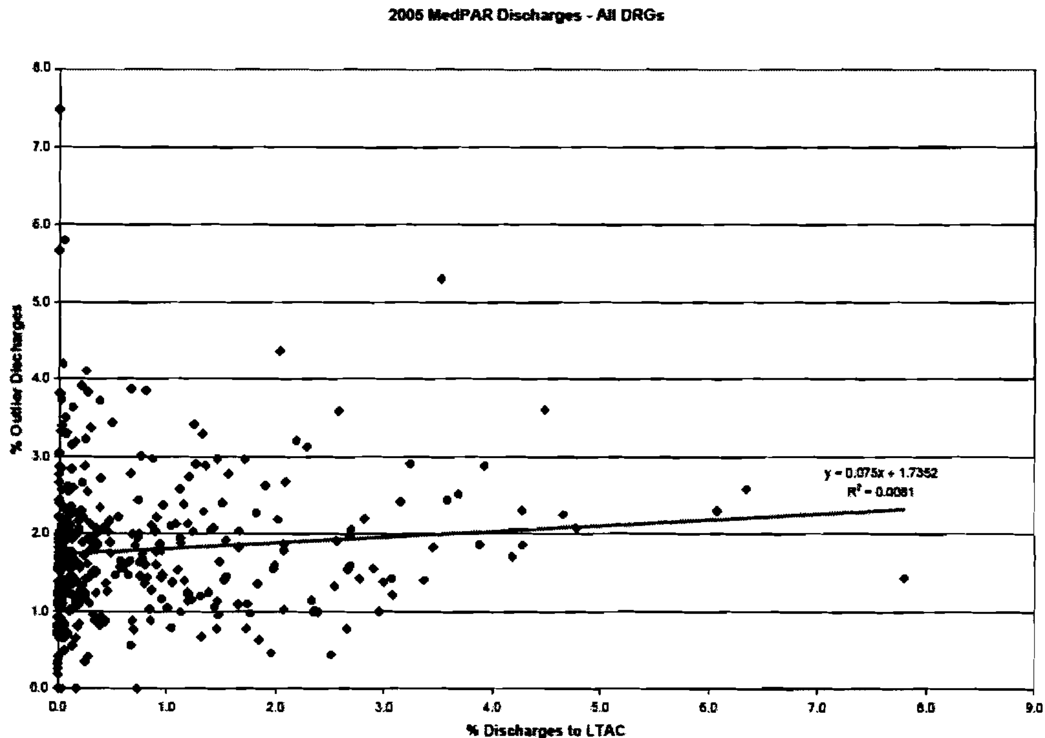
The following charts show the relationship between the percentage of high cost outliers in acute care hospitals and the percentage of total discharges to LTCHs in each of 385 metropolitan areas and metropolitan divisions. Using the appropriate field in MedPAR, the y-axis identifies acute hospital high cost outliers. The x-axis identifies for each acute care hospital the percentage of discharges to LTCHs. The individual data points on the graph indicate metropolitan areas with varying degrees of discharges to LTCHs. Data points as farther out on the x-axis indicate markets having a higher percentage of cases being discharged to LTCHs. If it

were true that utilization of LTCHs is related to a decline in short-term acute facility high cost outlier cases, the chart would show a downward sloping curve. With one exception, the chart shows an upward sloping curve that conflicts with any contention that short-term acute facilities are discharging patients early to LTCHs.

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

<u>All DRGs</u> (Chart 1): For all DRGs, the percentage of high cost outliers in acute care hospitals actually increases slightly as the percentage of discharges to LTCHs increases. Specifically, for every 1% increase in the percentage of acute hospital discharges to LTCHs, there is a corresponding .075% increase in the percent of acute hospital high cost outlier cases. This is directly contrary to any contention by CMS that discharges to LTCHs lower the percentage of high cost outliers at short-term acute providers.

Chart 1



<u>Top 10, 20, 30 and 50 Frequency DRGs</u> (Charts 2 through 5): This same pattern holds for the highest frequency DRGs among patients discharged from acute care hospitals to LTCHs. Specifically, the data show that as the percentage of discharges to LTCHs 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 squarely contradicts CMS' stated concern.

Chart 2

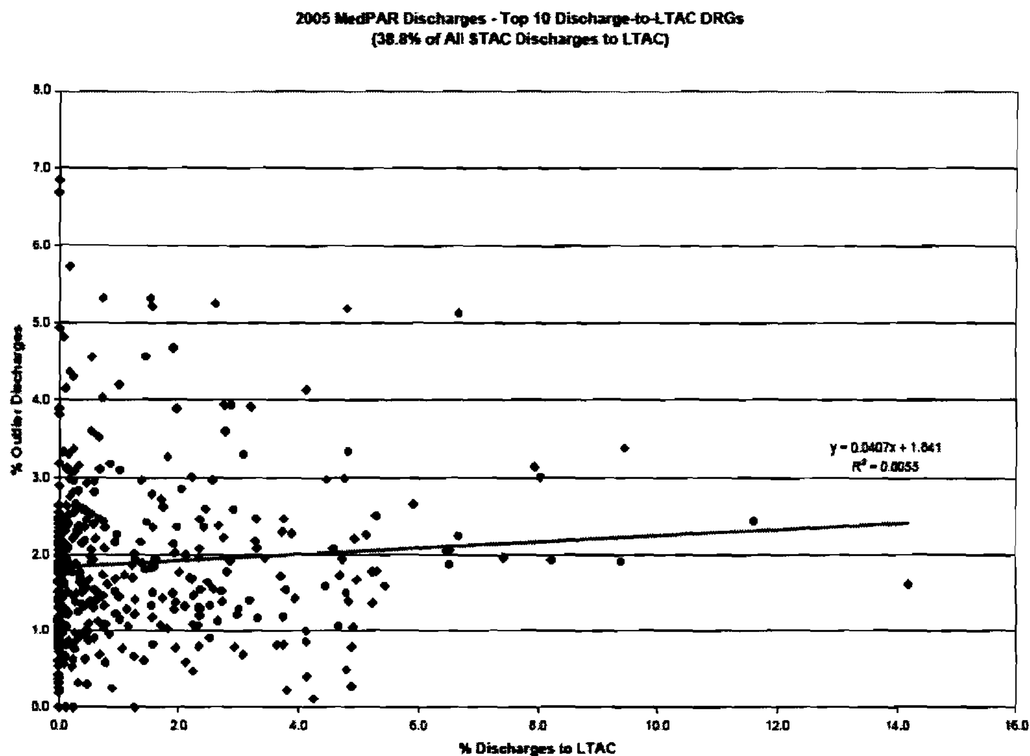


Chart 3

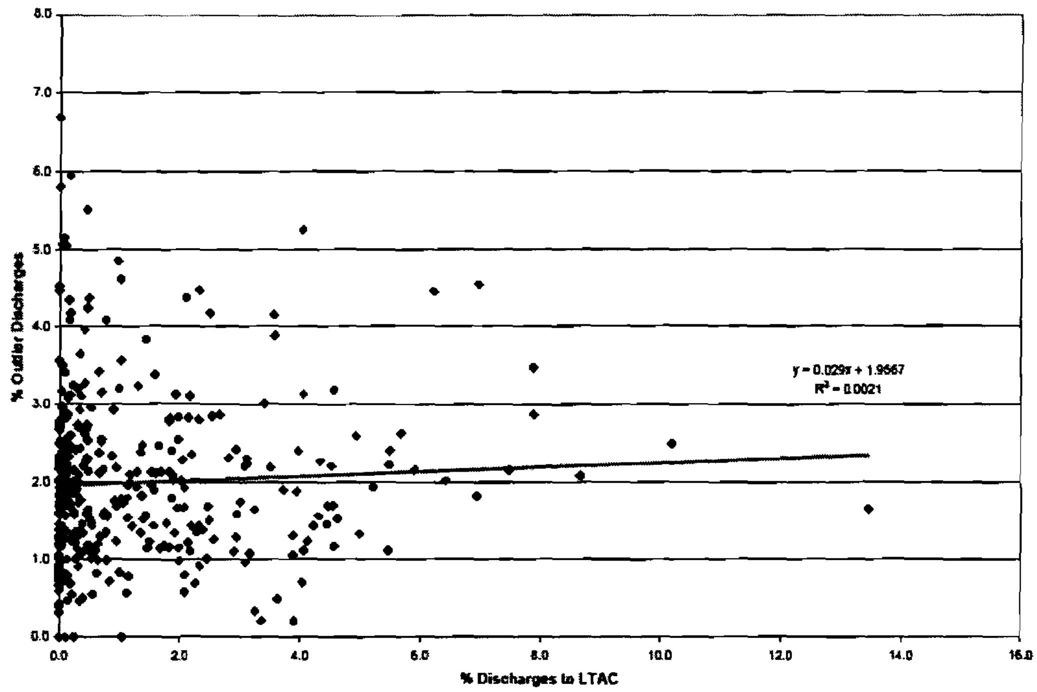

2005 MedPAR Discharges - Top 20 Discharge-to-LTAC DRGs
(55.4% of All STAC Discharges to LTAC)
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
% Outlier Discharges
0.0
2.0
4.0
6.0
8.0
10.0
12.0
14.0
16.0
% Discharges to LTAC
y = 0.029x + 1.9567
R² = 0.0021

Chart 4

2005 MedPAR Discharges - Top 30 Discharge-to-LTAC DRGs
(65.8% of All STAC Discharges to LTAC)

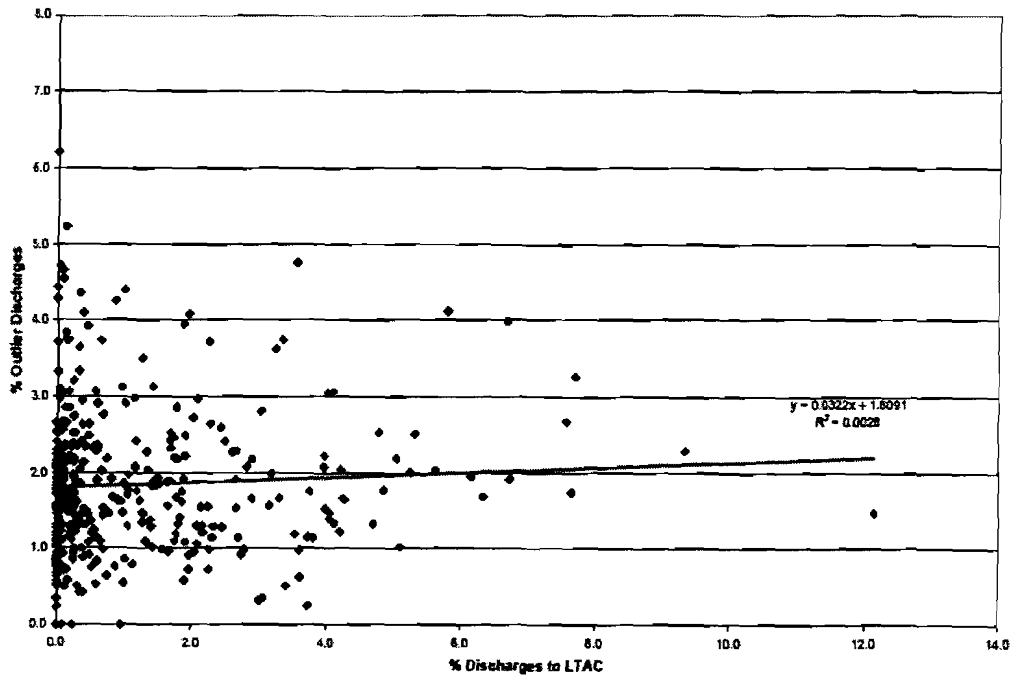
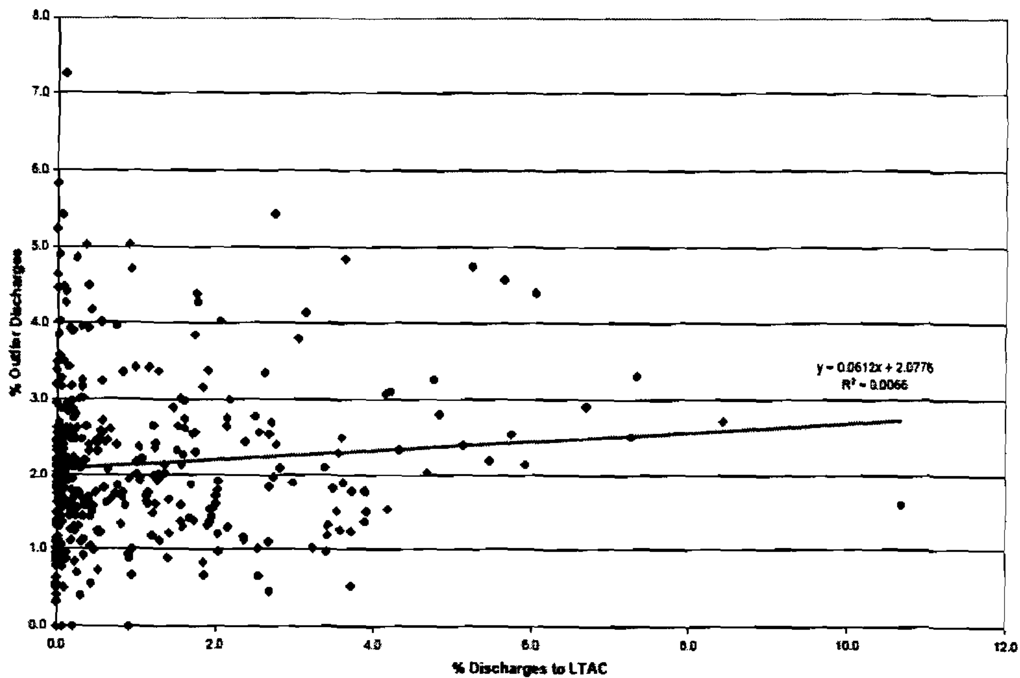


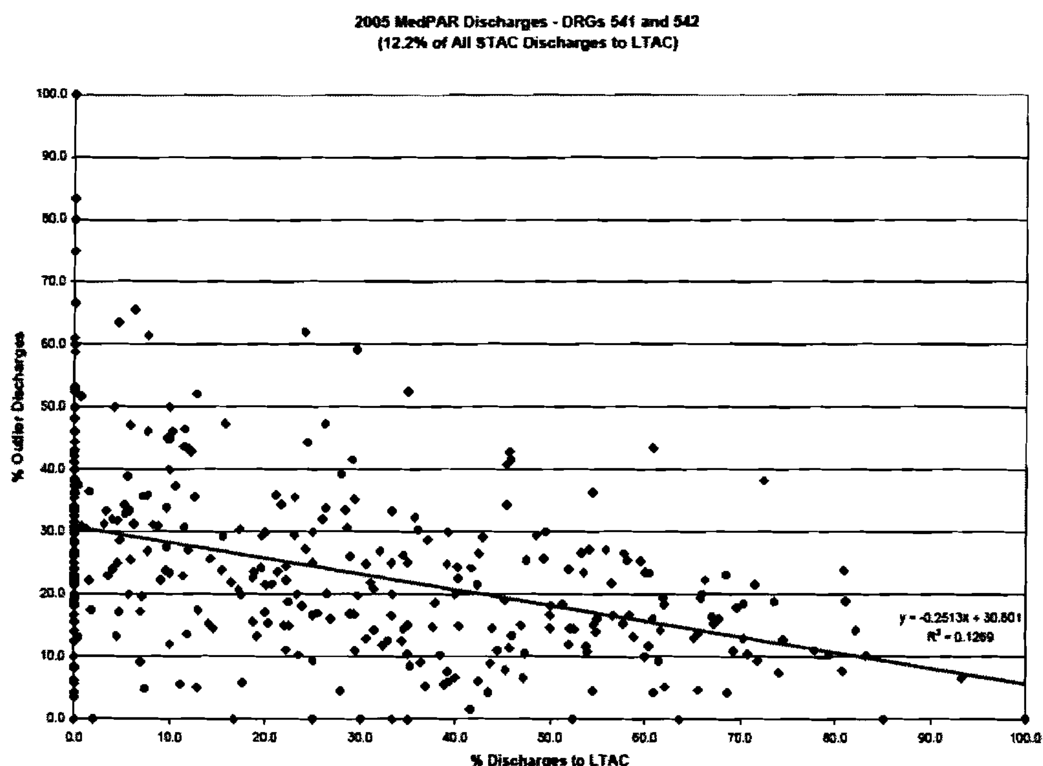
Chart 5

2005 MedPAR Discharges - Top 50 Discharge-to-LTAC DRGs
(76.8% of All STAC Discharges to LTAC)



<u>DRGs 541 and 542</u> (Chart 6): The one exception to these findings is for one type of patient discharged from short-term acute hospitals to LTCHs, 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%** (actually 0.25%) for every one percent increase in the percentage of cases discharged to LTCHs. In other words, the graph in Chart 6 does show a slight downward slope indicating that use of LTCHs affects somewhat the percentage of high cost outlier cases in acute care hospitals for these patients.

Chart 6

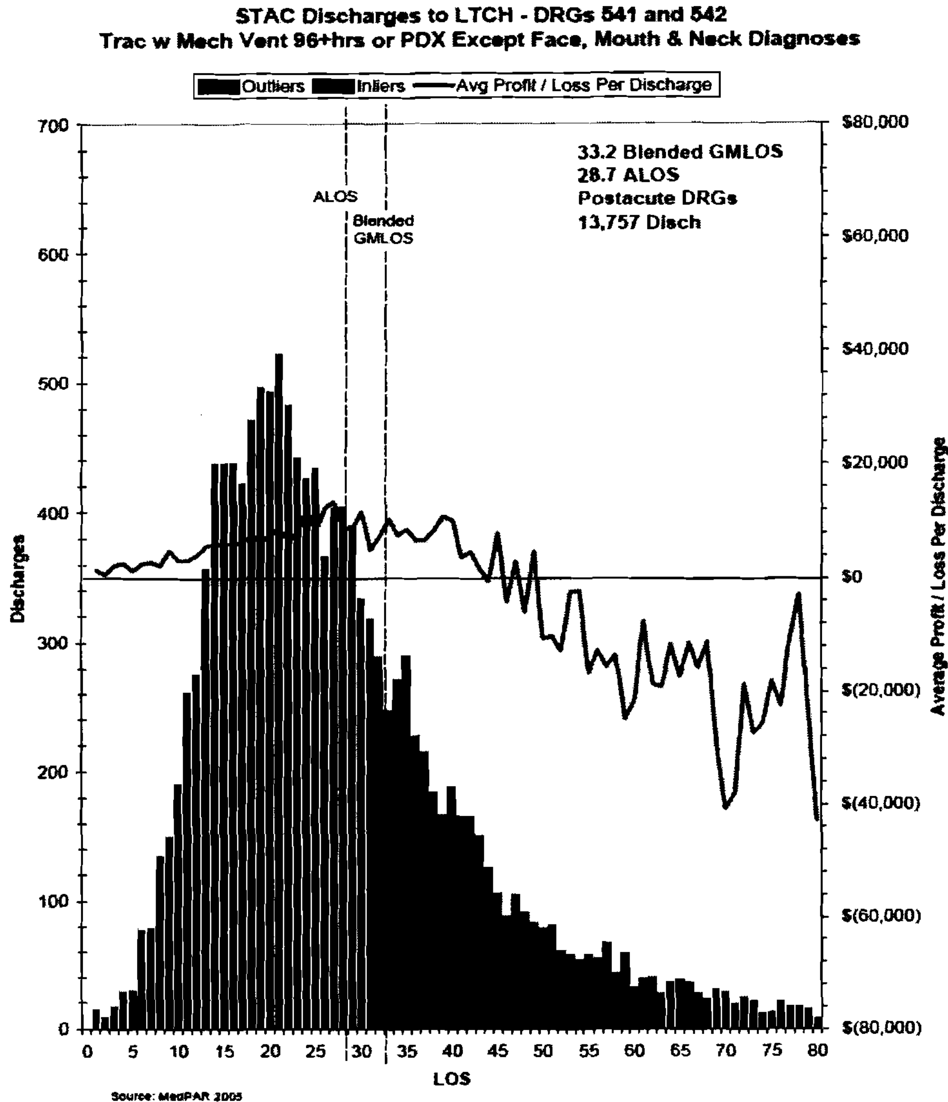


However, despite the correlation indicated by the chart, this pattern does not support CMS' apparent belief that LTCH utilization unduly increases costs to the Medicare program for three reasons:

- First, overall, the percentage of acute hospital high cost outliers for DRG 541/542 patients discharged to LTCHs (17.2%) and comparable patients not discharged to LTCHs (20.0%) is not significantly different; thus, there is no real correlation between outliers and either discharge to LTCHs or no discharge to LTCHs;
- Second, although trach/vent patients may be discharged "earlier" when LTCHs 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* Chart 7 below).

In other words, the majority of trach/vent patients discharged to LTCHs are paid less than the full DRG amount because they are discharged early. In addition, for trach/vent patients not discharged to LTCHs, 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 LTCHs.

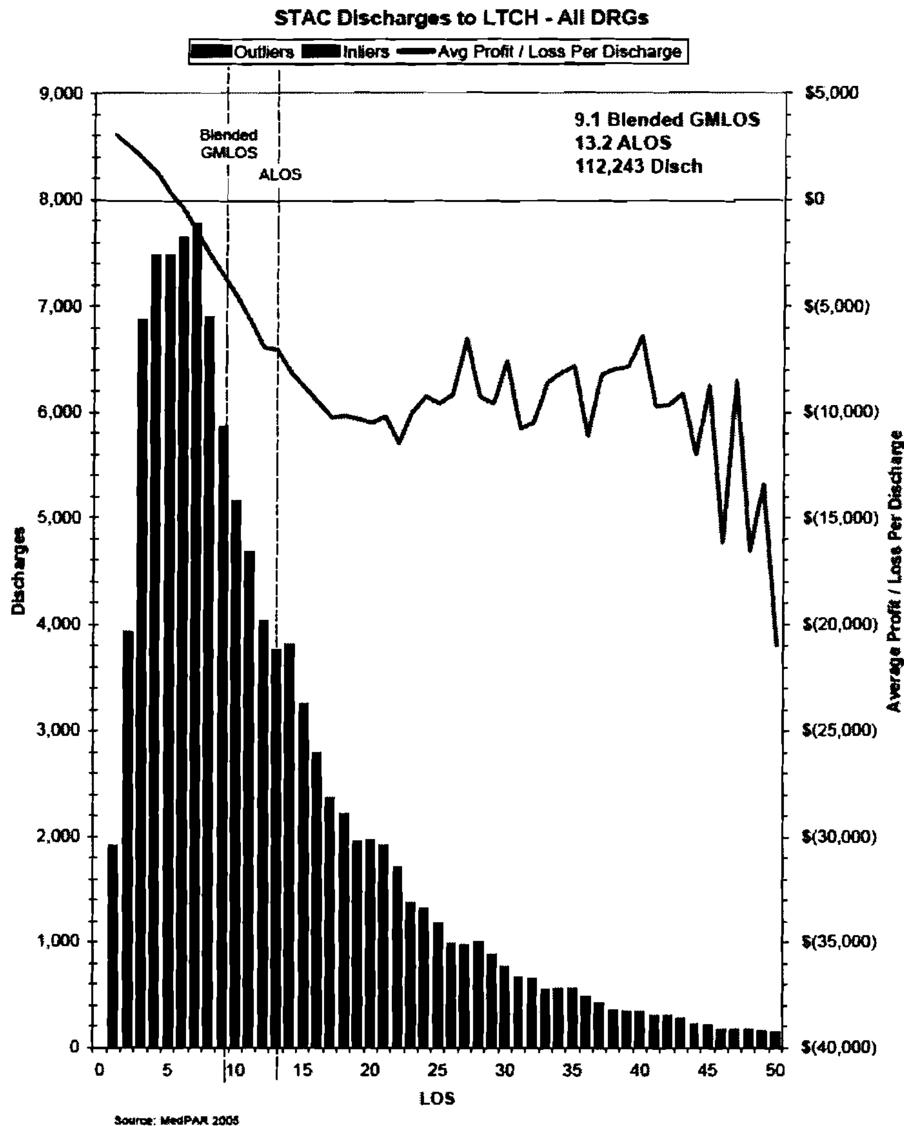
Chart 7



- 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 LTCHs. Accordingly, there is no reason for CMS to be concerned that for this subset of patients there is a somewhat lower percentage of high cost outliers when LTCHs are used.

The graph in Chart 8 shows that the average length of stay ("ALOS") for short-term acute hospital patients eventually discharged to LTCHs is more than 4 days longer than the geometric mean length of stay for patients in the same DRGs.

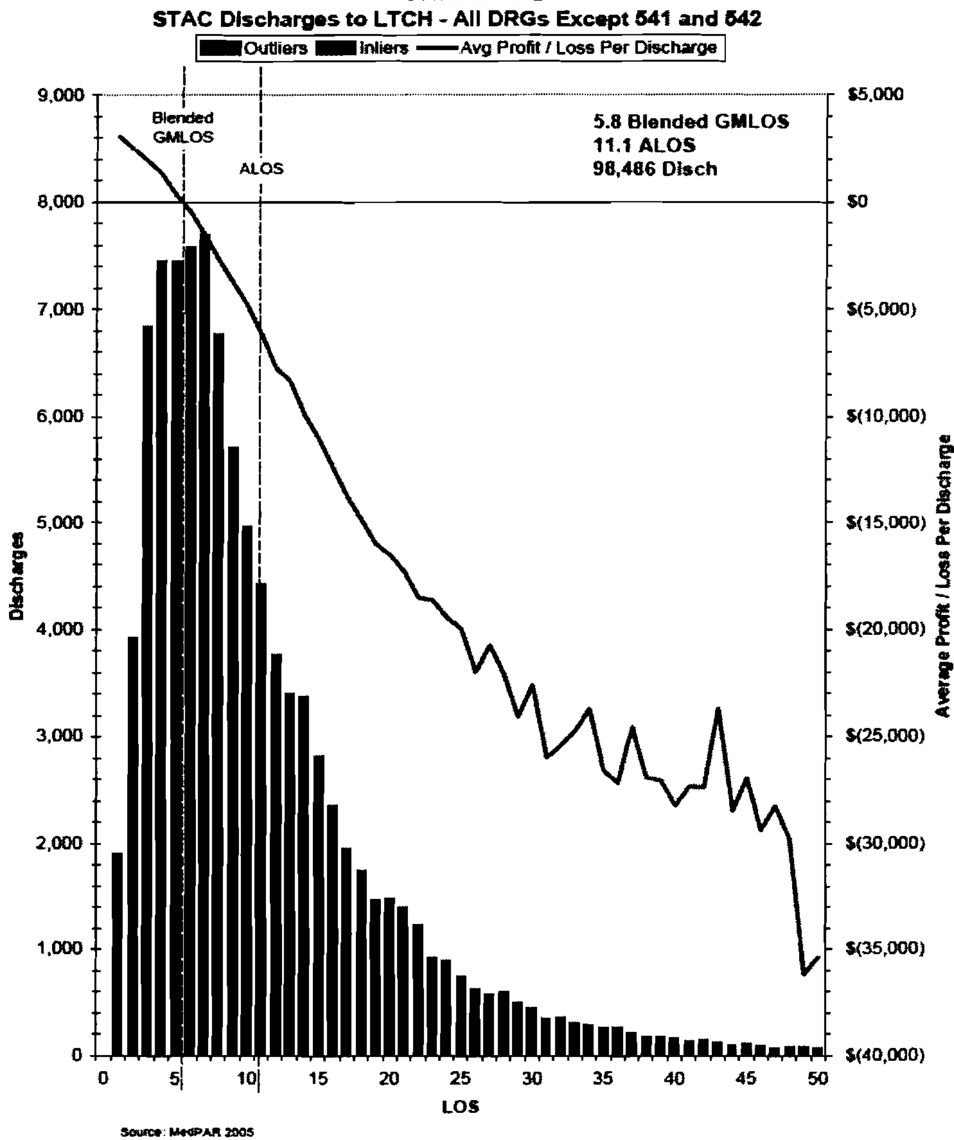
Chart 8



The graph in Chart 9 shows that among non-trach patients, the average length of stay for patients eventually sent to LTCHs 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 LTCHs are staying in the acute hospital longer than the average patient and that acute hospitals are not systematically discharging patients to LTCHs early for any reason. 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 but, importantly, payment is adjusted by the post

acute transfer policy for nearly 70% of these patients. A full 83% of the DRGs applicable to acute hospital discharges to LTCHs are subject to the post acute payment policy. There is simply no basis for alleging that short-term patients are being discharged to LTCHs to maximize profits.

Chart 9



5. CMS' Policy Change Is Either Unwarranted Or Premature.

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

The existing 25% Rule (or 50% rural rule, or percent of MSA dominant provider rule) has not yet fully been implemented; thus, the data, which lag by a couple of years anyway, are not complete, but CMS already wants to modify the policy. CMS has no or at best incomplete data to confirm that the 25% Rule is or is not achieving its stated policy goals and/or that it is having or not having adverse effects on patient care. There is no specific evidence of any type of which FAH is aware that short-term acute care hospitals are discharging patients to LTCHs, freestanding or otherwise, prior to the geometric mean DRG length-of-stay in the short-term acute facility. This certainly suggests that no specific attempt is being made to assure early IPPS discharge to promote a higher level of LTCH usage. Irrefutably, the application of the 25% Rule restricts physicians' choice of placement, patients' preferred placement to a particular long-term care facility, and interferes with the overall course of decision-making in placing patients in one level of care or another, and in one facility or another. It therefore seems to FAH that CMS should have clear data confirming the necessity of its 25% Rule policy and that the policy is not causing severe adverse effects on patient care, prior to modifying the 25% Rule so as to apply it more universally to all LTCHs, whatever their form, shape, location and relationship to other hospitals. Absent such data, CMS' current proposal is premature.

6. Most LTCHs Do Not Have A Dominant, Primary Referral Source That Demonstrates Inappropriate Patient Shifting.

CMS incorrectly contends that most LTCHs, whether freestanding or co-located HwHs, have a primary or dominant referral source that encourages premature discharge from a short-term treatment milieu and readmission to a LTCH setting of care. CMS incorrectly concludes, therefore, that since all LTCHs experience such a dominant, primary referral relationship, not just LTCH HwHs, the current 25% Rule should be expanded from co-located LTCH HwHs to all LTCHs, including freestanding LTCHs and previously grandfathered LTCH HwHs.

A careful review of this issue suggests, to the contrary, that CMS is basing its view on faulty data. In fact, the data actually available for review do not support CMS' assumptions.

First, 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. In its Preamble to the Proposed Rule, CMS claims to have analyzed data on relationships between LTCHs and acute care hospitals from which they receive a significant percentage of referrals. CMS purports to rely on the RY 2005 MedPAR files that indicate that only 12% of the then-174 freestanding LTCHs admitted 25% or less of their Medicare discharges from an individual acute care hospital; whereas 36% of those freestanding LTCHs admitted

between 25% and 50% from an individual hospital, and whereas a full 50% admitted more than 50% of their patients from a single short-term acute care hospital. CMS then states that this data regarding the concentration of referrals, together with the reported shorter stays at the shorter-term hospital prior to admission to the receiving LTCH "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." 72 Fed.Reg. at 4812. CMS indicates that it would have expected the length of stay at the acute care hospital that discharged patients to non-co-located LTCHs to be longer.

CMS' analysis, however, appears flawed. Given that (1) and RY 2005 (as opposed to later years') MedPAR data was reviewed, and (2) it is largely indisputable that patients admitted to LTCHs (as opposed to simply being discharged from the shorter-term hospital to other post-acute care settings) are more medically complex, there is absolutely no reason to leap to the conclusion that the concentration of referrals from particular short-term providers to particular LTCHs represent unacceptable patient shifting or "gaming the system" by both co-located and non-co-located LTCH providers working with compliant short-term care referral sources. To the contrary, what the data may well be saying instead is that there is no "gaming" or inappropriate patient-shifting occurring, and that the referral patterns mean only that there are strong geographic and physician continuity factors at play that are driving the concentration of referrals from a particular short-term provider to a particular LTCH. In addition, the data may more likely be showing that patients who are eventually admitted to LTCHs from these short-term providers, as opposed to being discharged elsewhere, are most appropriate for LTCH care and that these patients do better in settings that are most prepared to address and treat the specific medically complex conditions afflicting this particular group of patients.

The FAH believes that CMS is drawing conclusions without a thorough consideration of the available data. FAH requests that CMS first consider all of the available data *after* the close of the transition period already established for the existing 25% Rule, and then engage in a cooperative study with the LTCH industry regarding whether concentration of referrals from particular short-term providers to particular long-term providers is a good or bad thing. Only after that analysis will CMS be in a position to present more thoughtful policy proposals. Indeed, the data are by no means clear that consistent referral patterns are not actually what is in the best interests of the LTCH patients.

Second, the mere fact that many large hospitals are important sources of patients for specific LTCHs should come as no surprise or otherwise be troubling to CMS. Generally, patients and their families want to remain within a certain community or neighborhood for their care. To the extent a particular LTCH provides high quality services, why would a local physician or general acute care hospital placement office not seek to admit patients when necessary to that nearby LTCH within the same community?

It should also come as no surprise to CMS that any particular LTCH, in any one community, receives a substantial percentage of its patients from one or two large hospitals in the area. The demographics of hospitals have changed markedly over the past decade. Many hospitals have closed and/or consolidated; in some parts of the country there may only be one, or maybe two, large hospitals within any given community. Whether an LTCH is located in such a community or in part of a larger city, it is likely, if not virtually certain, that the closest quality

LTCH to such a larger hospital will receive a large number of its patients from that larger hospital.

There is absolutely nothing inappropriate about such referrals, provided the patients who are being admitted through such referral source are appropriate candidates for LTCH admission, which FAH and its members certainly believe they are in most cases. Indeed, FAH is not aware of any unusual or extraordinary denial rates for LTCH admissions involving its members, based on the results of CMS-contracted QIO reviews of LTCH admissions. CMS does not make a compelling case that inappropriate referrals constitute a reasonable basis to expand the 25% Rule.

7. CMS Policy Greatly Restricts Consumer Choice, Patient Access To Care And Interferes With Medical Decision-Making.

A fundamental tenet of the Medicare program since its inception has been to preserve consumer choice in seeking to access care, within reason, at an institution of the patient's choice. Yet, under CMS' expanded 25% Rule policy, a patient's choice of available Medicare participating LTCH facilities may exist unimpaired for only the first few months of a year. For many patients who unfortunately may need LTCH care in the second half of the rate year, and for Medicare budgetary reasons alone, patients may effectively be forced to be treated elsewhere in the city, perhaps tens of miles away or even in some cases hundreds of miles away simply because a LTCH has reached its arbitrary "quota" of a certain percentage of patients being referred to it from a particular short-term acute care hospital. The FAH believes that such a policy is contrary to this important tenet of the Medicare program to preserve patient choice. CMS' proposed expanded policy clearly discriminates against patients in the 26th percentile and higher with respect to numbers of referrals to LTCHs from individual short-term acute care hospitals.

Also, patients' access to care, itself, may be significantly impeded by the expansion of CMS' 25% Rule policy. In a not insignificant number of cases, once a 25% threshold is reached at one LTCH, and that LTCH decides no longer to accept any more Medicare patients from a specific referring hospital, the next closest LTCH in the town or area may well be full and also be unable to accept additional patients. Or, that other LTCH may also be at its 25% threshold if the referring hospital is a large tertiary medical center which feeds more than one LTCH a large number of patients. The patient may then be forced to access the LTCH level of care at a second, third or fourth choice, which may be in a completely different city, or even state, depending the location of the patient, the choice being to forego this level of care entirely. The FAH believes that such a peculiar and unfair (to the patient) outcome runs contrary to a most basic cornerstone on which the Medicare program is based, that is, that patients will be able to access the level of care they need at any given point in time. Congress established LTCHs as a distinct and separate level of care; such a level of care should be accessible to all patients in need of that care.

Furthermore, it is clear that CMS' expansion of the 25% Rule unavoidably interferes with medical decision-making. A patient's physician is virtually always in the best position to know to which facility a patient should be referred for follow up care after a short-term acute care hospital visit. In cases where a patient has suffered complications, and is likely to need complex,

longer-term stabilizing treatment in an LTCH, the physician is the one person who would know the specialties of each available LTCH in the general area (if more than one), the needs of the patient, the needs of the patient's family (if relevant) and where the physician has privileges to continue to be involved in the care for this particular patient. An LTCH to which a patient is being referred cannot determine ahead of time whether the patient is likely to experience a very short stay, or that a patient is being discharged too soon from the short-term acute care hospital. The LTCH must rely on the physician's judgment, as must the patient, and as should the Medicare program. It cannot be squared with Medicare policy to transfer a patient tens or hundreds of miles away to a facility which only fortuitously has not yet exceeded its 25% threshold on referrals from a particular short-term acute care hospital, where the transfer involves attendant risks of a complete changeover in approach, in medical team and all of the miscommunications that can occur with such a change. The policy underlying the expansion of the 25% Rule is squarely at odds with Medicare's historical support of physicians' exercise of their medical discretion to determine what treatment is in the best interests of patients in terms of post-acute care. The FAH believes that expansion of this policy may well also violate Section 1801 of the Social Security Act ("SSA") (42 U.S.C. 1395) – which states, in pertinent part:

> 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 on with the manner in which medical services are provided ...

Expansion of the 25% Rule could also violate Section 1802 of the SSA (42 U.S.C. 1395(a)) which states, in pertinent part:

> [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.

Preservation of patient choice has always been a basic principle not only of the Medicare program but also of the American health care system as a whole. FAH believes that CMS is creating dangerous new precedent by proposing policies that would interfere with patients being admitted to a LTCH in their community and/or of their choice, and the LTCH recommended by a particular physician, upon discharge from an acute care hospital. The perceived problem targeted by CMS is actually becoming less and less of a problem over time; thus, there simply is no basis to interfere with patient and physician choice to eliminate so small a potential risk to the Medicare program's finances.

In addition to Congressional direction, CMS also has incorporated the principle of patient choice and physician discretion throughout its regulations and interpretive materials. For example, a condition of participation in Medicare for hospitals is that they "as part of a discharge planning process ... inform the patient or the patient's family of their freedom to choose among participating Medicare providers of post-hospital care services and ...., when possible respect patient and family preferences when they are expressed." *See* 42 C.F.R. § 482.43. Likewise, in a CMS publication on Medicare rights and protections, CMS states:

> If 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.

See CMS Pub. No. 10112.

Furthermore, the Advisory Commission on Consumer Protection and Quality in the Health Care Industry, which has published a "Consumer Bill of Rights and Responsibilities" states that:

> [c.] Consumers have the right to a choice of health care providers that is sufficient to ensure access to appropriately high quality health care.

See Advisory Commission on Consumer Protection and Quality in the Health Care Industry, Consumer Bill of Rights and Responsibilities (November 1997).

Expanding the 25% Rule as proposed will clearly have the effect of interfering with medical decision-making, and in many cases, interrupting a patient's continuity of medical treatment. Such an outcome was not envisioned by Congress in identifying LTCHs as a separate level of care, nor is such an outcome envisioned by most stakeholders in the health care process. CMS should not allow its unfounded conclusions regarding individual hospitals' referrals to individual LTCHs, to so significantly interfere with patient choice, patient access to levels of care and the sanctity of medical decision-making.

8. It Would Be Inequitable To Apply The Twenty-Five Percent (25%) Rule (Or Other Applicable Percentage Rule) To Previously Grandfathered LTCHs Which Have Relied On A Series of Public Statements By CMS That Such LTCHs Would Not Be Subject To Subsequent Requirements Of And Restrictions On Other LTCH HwHs.

When CMS established the first set of separateness and control criteria and made them applicable to HwHs (*see* 42 C.F.R. §§ 412.22(e)(1) through (4)), Congress opted to exempt from these requirements LTCH HwHs that were in operation as HwHs and excluded from the IPPS on or before September 30, 1995. *See* section 4417 of BBA, Pub. Law 105-33; Section 1886(d)(1)(b) of the Social Security Act. When CMS then expanded its requirements applicable to HwHs and established the performance of basic functions criteria and the original 25% Rule (requiring that HwHs admit at least 75% of their patients from sources <u>other</u> than the host hospital), CMS codified this statutory requirement in regulation. *See* 42 C.F.R. § 412.22(e)(5). Once again, CMS exempted from these requirements LTCH HwH providers that were excluded from the IPPS as of September 30, 1995. *See* 42 C.F.R. § 412.22(f).

Likewise, when CMS first decided to establish the "25% Rule" as a special payment limitation applicable to co-located LTCH HwHs (but not other types of LTCHs or HwHs), LTCH HwHs which were excluded from the IPPS as of September 30, 1995 were, once again, excluded from application of the 25% Rule. CMS certainly had every opportunity to make the

fine distinction between grandfathering for separateness and control criteria purposes on the one hand, and grandfathering for payment limitation purposes, on the other hand, on several occasions, but yet chose not to do so. Now, however, suddenly, and in the absence of any data concerning these grandfathered LTCHs that would in any way support revocation of their grandfathered status, CMS seeks to reverse a decade of consistent treatment of these facilities and subject them immediately, fully and without any transition period, to an extremely stringent and inequitable limitation on admissions from co-located facilities.

Moreover, CMS' proposed action in this regard conflicts with CMS' own characterization of and justification for its existing and rather ironclad grandfathering policy.

The "grandfathering" of LTCH HwHs was not the result of a regulatory whim. Rather, Congress mandated that any LTCH that was classified by the Secretary of Health and Human Services 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. *See* Section 4417 of Public Law 105-33. Although CMS eventually expanded this "grandfathering" requirement to other hospitals within hospitals, Congress first proposed such grandfathering to benefit LTCHs, to the exclusion of all other providers.

When CMS first codified the LTCH HwHs grandfathering requirement in 1997, CMS (then the Health Care Financing Administration) specified that grandfathered HwHs would be excluded from the IPPS and would not be subject to any of the criteria in 42 C.F.R. § 412.22(e) [including the 25% Rule] if such hospitals had been excluded from the IPPS on or before September 30, 1995. *See* 62 Fed.Reg. 46014 and 46026 (August 29, 1997).

In 2002, CMS proposed the adoption of LTCH PPS, in response to a Congressional mandate that LTCHs be reimbursed under a PPS system. CMS again addressed grandfathering of LTCH HwHs that had previously been excluded from IPPS on or before September 30, 1995. CMS reiterated that Section 4417(a) of the Balanced Budget Act ("BBA") amended Section 1886(d)(1)(B) of the Social Security Act to provide that a HwH that was excluded from the IPPS on or before September 30, 1995, such as an LTCH, shall continue to be so classified. In that March 23, 2002 proposed rule, CMS further defined the qualifying HwH criteria stated in 42 C.F.R. § 412.22(e). *See* 67 Fed.Reg. 13415, at 13424. At no time in that proposed rule did CMS ever suggest that previously grandfathered hospitals would not continue to be exempt from the requirement that 75% of the LTCH HwHs' patients be admitted from sources other than the hospital with which such LTCH HwHs was co-located.

CMS then adopted a final rule implementing LTCH PPS on August 30, 2002. Therein, CMS again acknowledged that the BBA had amended Section 1886(d)(1)(B) of the Medicare Act to provide for grandfathering of LTCH HwHs which had been excluded from the IPPS on or before September 30, 1995. In addition, CMS acknowledged that grandfathered LTCH HwHs' would be exempt from the following requirements otherwise applicable to hospitals within hospitals:

> In order to prevent the shifting of costs within the Medicare payment system that would result from inappropriate transfers between the inpatient acute care hospital and the LTCH located

> within the acute care hospital, we have implemented additional qualifying criteria at Section 412.22(e) for these entities. These criteria require that in order to be excluded from the acute care hospital inpatient prospective payment system, a hospital located in or on the campus of an acute care hospital (referred to as a 'hospital within a hospital') must have a separate governing body, chief executive officer, chief medical officer, and medical staff. In addition, the hospital must perform basic functions independently from the host hospital, incur no more than 15% of its total inpatient operating costs for items and services supplied by the hospital in which it is located, **and have an inpatient load of which at least 75% of patients are admitted from sources other than the host hospital**. Originally, these regulations were effective as of October 1994. [Emphasis added.]

67 Fed.Reg. 55954, at 55963 (August 30, 2002).

As originally envisioned, therefore, the "25% Rule" currently in effect, was codified as a requirement that at least 75% of an LTCH hospital within a hospital's patients come from sources other than the host hospital. This is precisely the same premise as the rule at issue in the current Proposed Rule which states that if an LTCH HwH admits more than 25% of its patients from the host hospital, it can no longer qualify for reimbursement under LTCH PPS, but will rather be reimbursed as if it were a short-term acute hospital under IPPS for those patients in excess of the 25% threshold.

In fact, when LTCH PPS was adopted in 2002, CMS responded to a question from a commenter asking how LTCH HwHs previously grandfathered under Section 412.22(f) would be affected by the implementation of LTCH 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 2003, CMS made an even stronger statement in the FY 2004 IPPS Final Rule. Therein, under the heading "Payment for Services Furnished at Hospitals Within Hospitals and

Satellite Facilities," CMS reiterated that LTCH HwHs grandfathered under Section 412.22(f) were exempt from the criteria stated in Section 412.22(e)(1) through (e)(5) (the latter which included the requirement that LTCH hospitals within hospitals obtain at least 75% of their patients from sources other than the host hospital). CMS then stated:

> 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.

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 LTCH HwHs 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 LTCH HwH 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 LTCH HwH 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 LTCH HwHs. Nevertheless, in recodifying and restating the "75/25" Rule applicable to LTCH HwH admissions from their hosts and payment therefor, CMS continued to acknowledge that based on Congressional intent, and subsequent regulatory codification, LTCH HwHs that had been grandfathered under Section 412.22(f) would continue to be exempt from this "75/25" requirement applicable to other LTCH HwHs.

Merely because CMS chose to remove the 75/25 Rule from Section 412.22(e)(5) as it applies only to LTCHs, and then recodify and restate such rule as a payment limitation in Section 412.534, does not authorize CMS to evade the Congressional mandate and prior regulatory codification of grandfathering for LTCH HwHs that were excluded from the IPPS on or before September 30, 1995. It is illogical to give credence to CMS' suggestion that even though previously grandfathered LTCH HwHs 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 LTCH HwH 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 LTCH HwH would then be subject to IPPS reimbursement. Similarly, if an LTCH HwH fails to meet the 75/25 (the 25% Rule) limitation under Section 412.534, the result is little or no different; the LTCH HwH will be reimbursed at IPPS rates for all patients in excess of the 25% threshold. CMS' proposal would undermine the Congressional mandate for grandfathering of these facilities and should be rescinded in the final rule.

Finally, in 2006, CMS, in its Proposed FY 2007 IPPS Rule again acknowledged that Section 412.22(f) grandfathered LTCH HwHs would: "Continue to be paid outside of the IPPS, despite the fact, among other factors, no demonstration of operational or organizational separateness between these grandfathered entities and their host hospitals were required, as they were for HwHs established after September 30, 1995 … ." 71 Fed.Reg. at 24125 (April 25, 2006).

When the FY 2007 IPPS Final Rule was adopted, CMS again reiterated its support for grandfathering of LTCH hospitals within hospitals:

> At Section 412.22(f), we provided for the grandfathering of HwHs that were in existence on or before September 30, 1995, …
>
> As noted above, in establishing grandfathering provisions generally, we intended to protect certain existing hospitals and satellite facilities 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 F.R. 45463). …
>
> We reiterate that our grandfathering policy for HwHs was not established in order to limit HwH growth. Our goal, as noted above, was to enable hospitals excluded from the IPPS that were co-located prior to the recognition of HwHs as an entity to continue in their present arrangement with their 'host' hospital without having to comply with the regulatory framework that we were establishing for HwHs. …

71 Fed.Reg. 47870, at 48107-08 and 48114 (August 18, 2006).

LTCH HwHs that currently are grandfathered under 42 C.F.R. § 412.22(f) should continue to be grandfathered from not only the separateness and control criteria, but also from the severe payment limitation which CMS now proposes to extend to freestanding and previously grandfathered LTCHs. Simply stated, CMS' rationale for expanding the 25% policy to all LTCHs and LTCH satellite facilities, including previously grandfathered LTCH HwHs, is unexplained. This reversal of policy is harsh, unsupported, and unjustified in view of Congress' initial recommendation to the Secretary that a grandfathered class of LTCH facilities be established.

9. There Is No Evidence That LTCHs Are Evading The Existing 25% Rule By Establishing Freestanding LTCHs.

CMS continues to contend that LTCHs are seeking to "evade" the current 25% Rule by establishing non-co-located freestanding LTCH facilities. However, CMS provides no evidence of this activity. In addition, the current 25% Rule is not yet fully phased in; thus, any "trends" that may have surfaced in the very early stages of the 25% Rule transition period may have changed since that time. There is no evidence that CMS has ever studied these changing trends since the inception of the 25% Rule for co-located LTCHs. At best, expanding the current policy is premature at this time. If CMS' contentions are proven to be true at the <u>end</u> of the transition

period, and a proliferation of freestanding LTCHs continues to emerge, at least in CMS' view to evade the 25% Rule's effect, CMS can make the data available to the public at that time for review and comment, and then and only then should CMS propose new policies to address this perceived problem.

But, FAH believes that CMS' contentions in this regard have not been borne out and are thus factually incorrect. In fact, CMS' own data does not support its contentions. According to the October 2006 CMS Provider of Service File, FAH notes that there was actually a net **reduction** of LTCHs (by one provider) in 2006. Comparatively, there was a net increase of 28 LTCHs in 2005, half of which occurred in the very early part of the year. If anything, this change illustrates a dramatic **decrease** in the number of new LTCHs, and particularly freestanding LTCHs.

Developing a new hospital requires extensive planning. The growth in the number of LTCHs in 2005, by definition, reflects planned projects that were initiated in 2003 and 2004, well prior to the implementation of the existing 25% Rule in § 412.534. The recent reduction in the growth of LTCHs of all types reflects the implementation of the 25% Rule, as well as other anticipated effects of more stringent Medicare reimbursement policies. CMS has not allowed enough time to determine if existing changes to the LTCH PPS system will have had the corresponding and desired impact on the growth of new LTCHs. Even without expansion of the 25% Rule so as to apply to grandfathered LTCH HwHs and freestanding LTCHs, the growth of freestanding LTCHs has slowed almost to a standstill, and the number of grandfathered LTCH HwHs is obviously frozen at the level it was in the mid-1990s. Based on these findings and current trends, FAH believes there is no support whatsoever for expanding the reach of the 25% Rule to limit admissions to freestanding LTCHs and/or previously-grandfathered LTCH HwHs and satellite facilities.

CMS has, once again, jumped to a conclusion regarding proliferation of freestanding LTCHs, and is not looking at the data from the past year or two, when the pace of expansion has greatly decelerated, almost to nothing. CMS also fails to take into account the effect on the industry that the RY 2007 LTCH PPS Rule has had in deterring LTCHs of all kinds from being established given the draconian reductions to LTCH reimbursement that were codified in last year's LTCH PPS Rule.

Moreover, to the extent freestanding LTCHs were in the past established, or in the future are established, such LTCH development, to the extent it is structured to fall outside the scope of the 25% Rule, should not and cannot be viewed as "evading compliance" with the Rule. Establishment of a freestanding LTCH that is not covered by the 25% Rule is appropriate and proper, and does not evidence, in and of itself, intent to evade compliance.

The FAH believes it important to remind CMS that Congress, itself, established long-term care hospitals as a distinct and separate level of care. In addition, both Congress and CMS, as well as the provider community, have recognized for many years that long-term care hospitals fulfill an important mission in providing a distinct level of care along the overall continuum of acute care. Few if any other providers can marshal the resources and focus necessary to treat this most difficult group of patients with complex, multiple and serious diseases and conditions that often do not respond to treatment in any other type of facility.

It must also be stressed that the United States is currently experiencing unprecedented growth in its population of senior citizens and a palpable aging of its population. It is to be expected that life threatening, serious multivariate medical conditions will afflict these more elderly patients. LTCHs are designed, in large part, to address this growing problem. For CMS to place series after series of arbitrary restrictions and payment limitations on LTCHs and to single LTCHs out for such punitive treatment when such providers are merely responding to a medical need, is contrary to Congressional policy and the interests of the patients who now need and in the future will need LTCH services.

10. The Proposed Rule Will Harshly Impact LTCHs In Areas With More Limited Referral Sources.

If finalized, the Proposed Rule will more harshly impact LTCH providers in areas with less than four short-term acute hospitals. In these smaller or more concentrated short-term acute care markets, it is likely that medically complex patients will not be evenly distributed. LTCHs frequently get their patients from tertiary care centers, where the sickest and most medically complex patients tend to cluster. A strict percentage limitation system, such as CMS proposes to adopt, if applied evenly to all short-term care hospitals in that market, will likely preclude LTCHs from operating as efficiently and effectively as the Medicare program envisions. If referrals are restricted, it is likely that the restrictions will apply to referrals from the short-term acute care hospital whose caseload generally is most likely to include patients in need of LTCH services. Thus rather than supporting the efficient referral and discharge relationships between short-term acute care hospitals and long-term acute care hospitals, and providing for more or less seamless movement along a continuum of care for medically complex patients, CMS would artificially restrict and interrupt these relationships based on incorrect assumptions. Moreover, the penalty CMS proposes will affect adversely not only LTCHs, but also other acute and post-acute providers who will be forced to care for these extremely sick patients.

It is likely, therefore, that the restrictions' effects will be felt in the areas most underserved already. Imposing a ceiling of 50% of referrals from any one hospital from any one hospital for LTCHs in dominant-MSA areas, rural areas and similar underserved areas will not solve the problem. Some of these LTCHs have only one short-term acute care hospital referral source. In these areas, by definition, a 50% rule will limit access to patient care, restrict patient choice, and interfere with medical decision making in up to 50% of cases that may be quite appropriate for LTCH care. In these areas, patients above the 50% threshold will not only be limited in their choice of provider, but many patients on a very practical level will be unable to access LTCH care. In this way, applying admission limitations to rural LTCHs may have a compounding effect. Rural areas have fewer short-term providers and long-term providers. Expansion of the limitation will result in an undetermined number of patients in underserved areas who cause the sole LTCH to exceed the admission threshold on referrals from the sole short-term acute facility, to be denied care in the setting most appropriate to their condition. At any level, this makes no sense from a programmatic policy standpoint. And CMS' proposed policy, as discussed more specifically above, will work this significant impact on patient care without any real evidence of the problem that the policy ostensibly seeks to avoid.

11. Existing CMS Policy Already Responds To CMS' Stated Concern That Medicare Is Somehow Paying Twice For The Same Episode Of Care.

Existing policies sufficiently address CMS' stated concerns underlying CMS' new policy proposal. Among existing policies which address these concerns are (1) the 5% readmission policy -- which limits the number of patients that can be readmitted to LTCHs following treatment in a short-term care acute facility; (2) the three day or less interruption of stay policy -- which precludes LTCHs from being reimbursed a second time following a short interruption of LTCH stay where the patient is discharged to a short-term acute provider for intensive treatment, but then returns to the LTCH; and (3) the post-acute transfer/discharge policy -- which places stringent limits on numerous DRGs with respect to how post-acute treatment will be reimbursed under Medicare for those selected DRGs. The data show that adequate restrictions are in place. Expansion of the 25% Rule to freestanding LTCHs and grandfathered LTCH HwHs is entirely unnecessary.

12. LTCHs Employ Adequate Screening Instruments To Determine Who Are Medically Complex Patients Appropriate For LTCH Care.

FAH and the LTCH community, at large, believe that the Proposed Rule does not appropriately target cases that are most likely to result in inappropriate admissions. LTCHs already use adequate patient screening protocols to determine which patients are medically complex and thus appropriate for LTCH care. FAH believes that CMS should focus on establishing patient and facility level criteria for LTCHs to better define which patients an LTCH should treat and the medical conditions that will be required for admission, rather than drawing questionable assumptions about the appropriateness of admissions from a very incomplete set of data. FAH notes that a defining set of facility and patient criteria have now been proposed by the U.S. House of Representatives ("H.R. 562") and the Senate ("S. 338") to help establish new LTCH certification criteria that would far better address CMS' stated concerns in this area. Instead of taking such a broad, and carefully targeted approach, however, the Proposed Rule seeks to impose a very arbitrary limitation on LTCH payment which fails to advance CMS' stated goals.

It has been FAH's experience that LTCHs admit patients only after applying objective and carefully drawn sets of admissions screening criteria. Medicare QIOs then conduct post-admission reviews of LTCH patients to ensure that each admission is medically necessary. In fact, at CMS' direction, QIOs have reviewed a sample of LTCH cases for appropriateness of admission. FAH notes that for two of its largest LTCH organization members, the QIOs have determined that the vast majority of LTCH admissions were appropriate and medially necessary. In one case (Kindred Health Care, Inc.), and a second case (Select Medical Corporation), after over 1,000 LTCH cases were reviewed by QIOs in the aggregate since 2003, the combined denial rate for these two LTCH organizations stood at only 1.6%.

Under any standard, therefore, this data indicates to CMS that only an insignificant number of LTCH claims have been denied as a result of QIO reviews, which certainly suggests that the LTCH admissions in general are appropriate. There was no evidence derived from the QIO reviews suggesting that cases were inappropriately admitted to LTCHs as a result of LTCHs acting as extension sites or units of short-term acute providers, or patients receiving less than a full episode of care at a short-term provider. To the contrary, QIOs have overwhelmingly found that LTCH patients have appropriately been admitted and cared for in LTCHs.

13. Numerous Practical Deficiencies Plague The Proposed Rule, Rendering It Very Difficult For LTCHs To Monitor Compliance With The 25% Rule.

CMS appears to have failed to consider several practical considerations regarding how LTCHs are expected to comply with the proposed expansion of the 25% Rule. For example, FAH is unaware of any mechanism whereby LTCH providers can obtain outlier data from short-term acute care hospitals in order for LTCHs to self-monitor compliance with a 25% Rule that excludes short-term hospital outliers from the 25% threshold. Thus, whereas the proposed language states that LTCHs are to exclude from the 25% threshold patients "on whose behalf the Medicare outlier payment was made to the referring hospital," these same LTCHs cannot practically determine which patient stays constituted outliers at the short-term hospital.[2] As a practical matter, moreover, the LTCH becomes totally dependent upon the accuracy of the data supplied by the referring short-term hospital, even though typically a short-term referring hospital will not be familiar with the specific payment status of a referred patient at the time of his/her discharge from the short-term provider and admission to the LTCH. Indeed, a referring short-term provider is unlikely to submit final bills on its discharged patient until long after the admission to the LTCH.

In other cases, changes can occur to the Medicare billing as a result of a review by CMS or the fiscal intermediary. It is unlikely for a short-term provider to then contact the LTCH to which the patient was admitted about this payment change affecting only the short-term provider.

The effect of the Proposed Rule is exacerbated in its application to freestanding facilities. Generally, the relationships between co-located facilities are much closer than typical interactions between hospitals that are freestanding and separated from one another. For example, an LTCH HwH is likely to have greater access to the staff of a co-located hospital, which can somewhat more easily provide and confirm outlier data. Conversely, freestanding LTCHs are not likely to have regular interaction with hospitals that are located elsewhere in a town or city, and a patient's medical records and other information sent to an LTCH in connection with an patient's admission will not reference whether a Medicare outlier payment is being made to or sought by the referring hospital.

Thus, as the Rule has been proposed, it will be difficult, at best, for freestanding LTCHs to monitor compliance with the 25% restriction during any given fiscal year. Without assurance that it is not exceeding the admission threshold, an LTCH becomes exposed to a tremendous degree of risk of incurring an overpayment at the end of each cost reporting year.

When it established the initial 25% Rule in the RY 2005 final LTCH PPS Rule, CMS indicated that it wanted to place into effect a simple rule whereby "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. 49194. While the proposed new language may work for fiscal intermediaries, it clearly will not work for the

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[2] Ironically, since there is no mechanism for sharing this information, it is left to the LTCH to establish a close relationship with the referral source (ostensibly, the very result CMS purports to want to avoid).

LTCHs themselves, since the LTCH providers will be unable to determine their compliance (or lack of) with the Proposed Rule until long after the end of an LTCH's cost reporting year. Given the financial implications of noncompliance, LTCHs must be afforded a mechanism to effectively monitor compliance on an ongoing and continuous basis. However, CMS offers no structure or process that can be used to monitor an LTCH's compliance with the 25% threshold, and there are no mechanisms or documents that LTCHs are directed to rely upon in self-monitoring their compliance.

For some LTCH providers, it is even more difficult. For example, there is an exception to the proposed 25% Rule for LTCHs that are located in an area of a "MSA-dominant" hospital. MSA-dominant hospitals are facilities that discharge more than 25% of the patients in the MSA in which that hospital is located. This limited exception purportedly permits an LTCH to accept the percentage of Medicare patients that the MSA-dominant hospital is responsible for discharging in that MSA, but no more than 50%. In determining its ongoing compliance with this part of the restriction, an LTCH would also be required to monitor on an ongoing basis the percentage of discharges at the MSA-dominant hospital. During its cost reporting year, an LTCH has absolutely no mechanism for determining what percentage of discharges the MSA-dominant hospital is responsible for in its MSA. The proposed regulation offers no assistance in this regard, nor does it explain how CMS will monitor compliance with the requirement. This creates, at best, a challenging and troubling environment for both freestanding LTCHs and previously-grandfathered LTCHs.

In yet another departure from prior CMS policy, this newly-proposed expansion of the 25% Rule offers virtually no transition period. The first (actually, the only) stage of the transition period, which covers cost reports beginning on or after July 1, 2007, and before October 1, 2007, limits LTCH admissions from each referral source to the lesser of 50% or the percentage of Medicare discharges that were admitted from each referring hospital during the LTCH's 2005 cost reporting period. Compared to the far more reasonable transition periods within which other LTCH providers have been able to adapt their operations to new rules and restrictions, CMS has taken an usually harsh approach in providing essentially no transition period for previously-grandfathered LTCH HwHs and freestanding LTCH facilities. Instead, CMS proposes making such providers fully subject to the full force of the 25% threshold for any cost reporting period that begins on or after October 1, 2007, only a few months from now. Indeed, the only providers that benefit from any transition period at all in this regard will be those providers with cost reporting years beginning on or after July 1, 2007, and before October 1, 2007, and for a period of only three (3) months. The FAH is unaware of any similarly harsh transition period in the Medicare program and strongly objects to implementation of this provision without a reasonable transition period on that ground.

14. CMS Fails To Provide Data Supporting A 2.2% Reduction In Aggregate LTCH Payments For RY 2008 Resulting From Expansion Of The 25% Rule.

CMS estimates that the extension of the 25% Rule to previously grandfathered LTCH HwHs and freestanding LTCH providers will result in a 2.2% reduction in aggregate LTCH payments for RY 2008. CMS offers no data in its Proposed Rule to support this estimate, which could turn out to be an even greater reduction, and certainly a greater reduction for those affected freestanding and previously grandfathered LTCH providers. Without supporting data, however,

the FAH cannot meaningfully comment on this aspect of the Proposed Rule. The FAH is aware some "sister" trade associations also representing the LTCH industry have filed expedited requests under the Freedom of Information Act seeking this data, but to date, the FAH does not believe it has been provided. Certainly, the entire industry needs to review this data carefully to verify the accuracy of CMS' estimate, prior to being able to comment meaningfully on this part of the Rule.

15. FAH Recommendations.

(a) CMS should not extend the current 25% Rule, or any similar policy, to freestanding LTCHs or LTCH HwHs previously grandfathered under 42 C.F.R. § 412.22(f). The proposed expansion of the 25% Rule is inequitable, extremely difficult to comply with, and discriminatory against patients, providers and healthcare professionals alike.

(b) If, despite these serious deficiencies of the Proposed Rule, CMS decides to finalize this policy, it should:

(1) Provide for a longer phase-in period – at least as long as the phase-in period for LTCH HwHs and satellites (a full four-year transition period);

(2) Continue to grandfather, consistent with all prior CMS policy on LTCHs, all existing and under-development freestanding LTCHs from the Rule altogether;

(3) Establish the applicable percentage for all freestanding and previously grandfathered LTCH HwHs at 50%. Freestanding LTCHs do not present the same policy concerns CMS has expressed regarding co-located facilities, and whereas there is no ongoing growth potential for the class of previously-grandfathered HwHs – if an LTCH HwH was not grandfathered by the mid-1990s, it will already be subject to the 25% Rule under existing regulatory language; and

(4) Limit the 25% Rule extension to LTCH discharges who had the same DRG upon discharge from the short-term acute hospital to which the LTCH patient was previously admitted.

C. Short Stay Outlier ("SSO") Policy

1. CMS' Proposal.

The Proposed Rule would further revise the payment adjustment formula for LTCH SSO patients, even though no data from last year's major overhaul of the SSO reimbursement scheme is yet available. SSO cases are defined as LTCH PPS cases with a length of stay of less than or equal to $5/6^{th}$ of the geometric mean length of stay for each long-term care ("LTC") DRG. Currently, payment for SSO patients is based on the lesser of (1) 100% of estimated LTCH 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 its Preamble to the Proposed Rule for RY 2008, CMS states that it is now considering a potential further reduction to reduce LTCH payment to the IPPS rate for SSO 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 presumptive "IPPS comparable threshold"). Under this new proposal for RY 2008, SSO cases with covered lengths of stay that exceed the "IPPS comparable threshold" will continue to be paid under the current SSO payment policy, which, importantly, itself is often far less than the actual "cost" to the treating LTCH provider. Where LTCH cases fall within the geometric average length of stay of an IPPS case DRG plus one standard deviation, however, the LTCH SSO case will apparently be paid only the IPPS DRG amount for that case according to CMS' proposal, although this new payment methodology is not fully explained.

CMS references DRG 475 (respiratory system diagnosis with ventilator support) and DRG 483 (trach with mechanical vent 96 plus hours or PDX except face, mouth and neck diagnosis) as examples where the number of "recuperative" days are considerably shorter at the acute care level if a discharge from the acute care hospital was followed by an admission to an LTCH. CMS apparently believes that the data for DRG 475 and DRG 483 support CMS' belief that LTCHs are admitting certain SSO patients who perhaps could and should have remained admitted to the acute care hospital to which the patient was first admitted.

CMS now proposes to change further the SSO policy based apparently on the consideration of whether the same DRG should 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 contends that SSO cases with length of stays similar to the average length of stay for short-term acute hospital patients require similar resources and, as a consequence, should be paid akin to how such treatment would be reimbursed under IPPS at a short-term acute care hospital. CMS contends continually in its Proposed Rule that it is overpaying for SSO cases in LTCHs where the patient's length of stay is equal to or less than the typical IPPS average length of stay.

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

2. Further Changes To SSO Reimbursement Policy Are Premature.

The FAH believes that further changes to the SSO policy are seriously premature; CMS has had no meaningful opportunity to evaluate the effect of major changes to this policy implemented less than one year ago. The existing SSO policy only became effective as recently as October 1, 2006 for some providers, and only slightly prior to that time for others. Consequently, a major overhaul to the SSO policy will have been in effect for considerably less than one year before this new Proposed Rule takes effect. Yet, in the Preamble to the Proposed Rule, CMS suggests that "[s] subsequent to the RY 2007 LTCH PPS Final Rule, we have performed additional analysis of more recent data FY 2005 MedPAR data." 72 Fed.Reg. 4805.

Analysis of the **FY 2005** MedPAR data, however, does not take into account at all the existing policy (implemented in mid-**2006**) the current impact of which is completely undetermined. In seeking to justify the most recent major changes to the SSO policy in the RY 2007 Final Rule, CMS declared that it had "formulated a payment adjustment under the LTCH

PPS that [it] believed would result in an appropriate payment adjustment for those inpatient stays that are not characteristic of LTCHs but could be more appropriately treated in another setting." *See* 72 Fed.Reg. 4805. Prior to racing to adopt yet another change and adding an even more stringent payment limitations to the existing SSO policy, the FAH believes CMS must determine if the change implemented in RY 2007 has achieved its intended objective. It is not possible for CMS to know now the impact of its most recent change to SSO policy.

FAH believes, as do most in the LTCH industry, that the changes to SSO reimbursement made last year have eliminated the incentive to knowingly admit inappropriate SSO cases. By reducing the option that SSO cases be paid from 120% of the estimated cost of a case to 100% of cost, the RY 2007 Final Rule adequately discouraged inappropriate admission of patients that do not typically belong in LTCHs, but who could be more appropriately treated in another setting. The FAH does not believe that receiving 100% of one's estimated costs gives a provider any incentive to seek out such patients. Reducing the SSO payment further will result only in additional cuts in LTCH payment before LTCHs, CMS, and other stakeholders have had an opportunity to study the impact of the 2007 reduction. In addition, further reductions to SSO reimbursement are likely to constrict further the availability of LTCH services, which will work a tremendous disservice to patients in great need of these services.

3. The Proposed Rule Inaccurately Presumes That LTCH Cases With Lengths Of Stay Within The IPPS Comparable Threshold Are No Different Than Cases In Short-Term Acute Care Hospital Providers.

FAH regards CMS' SSO policy proposal for RY 2008 as deficient on the basis that CMS compares LTCH SSO cases to short-term acute cases using only length of stay. LOS is not the sole, nor even the most appropriate, barometer of the similarity or dissimilarity of LTCH versus short-term acute cases. CMS' comparison fails to take into account patients' severity of illness, multiplicity of debilitating conditions, and other non-length of stay factors, all of which clearly demonstrate that LTCH and short-term acute patients with the same DRG most often are **not** the same kinds of patients.

For example, in the Proposed Regulation, CMS characterizes various SSO cases as cases whose episodes of care in the LTCH purportedly resemble the corresponding episodes of care in a short-term acute provider based solely on the length of stay of each SSO DRG in the LTCH. Analyzing these IPPS comparable cases using MedPAR 2005 data, however, shows that very short stay outliers ("VSSO") are, indeed, more clinically similar to other LTCH cases than to short-term acute care cases in terms of these VSSO patients' acuity. For the ten most common LTCH DRG types, the VSSO cases exhibit a similar percentage of cases in severity of illness categories "3" and "4" (higher severity) to all LTCH cases, and a much higher percentage of cases in severity of illness categories "3" and "4" than do short-term acute care hospital patients. *See* Table 3 to Comments submitted by Acute Long-Term Hospital Association ("ALTHA") to RY 2008 Proposed Rule, dated March 23, 2007, attached hereto as Exhibit 2. Notably, the only DRG where there appears to be no significant difference between short-term acute patients of a particular DRG and LTCH patients who are VSSOs of the same DRG is DRG 475. FAH believes that it is grossly incomplete for CMS to base its request for additional and severe policy change on the basis of one common DRG, when in fact, looking at the vast majority of DRGs and comparing their use in short-term care and long-term care providers, the evidence suggests

overwhelmingly that LTCH VSSO cases have much higher acuities than similar cases of the same DRG in short-term acute hospitals.

As FAH has noted in previous comment letters, it is impossible for an LTCH provider to determine upon admission a given patient's length of stay and DRG classification. Generally, LTCHs admit patients because a longer length of stay is anticipated. Determining whether to admit a patient who ultimately becomes a VSSO, therefore, is clinically and medically challenging, since these patients appear clinically similar (within virtually all DRGs common to both short-term and long-term providers) to other patients admitted to an LTCH. Whereas these LTCH VSSO cases are far more clinically similar to other LTCH cases than to short-term acute cases within the same DRG, for the vast majority of common DRGs, FAH believes it is appropriate and warranted for the Medicare program to pay for these admissions under LTCH PPS.

LTCH PPS reimburses cases based on a law of averages. There will be very long admissions, and very short admissions; what is anticipated is that the average length of stay will be considerably longer than the average length of stay in a short-term acute hospital, which the data suggests is in fact the case.

4. The Proposed Rule's Changes To SSO Policy Incorrectly Presume That SSO Patients In LTCHs Continue The Same Episode Of Care That Begins In A Short-Term Acute Care Provider.

At best, there are no data supporting the conclusion that SSO patients continue the same episode of care that had previously begun in a short-term acute care provider. In fact, what data do exist suggest the opposite is true, and that SSO patients do not continue the same episode of care that begins in the short-term care provider.

As FAH discusses above, a report prepared by RTI at the request of CMS indicates that the question of whether patients are transferred before receiving a full episode of care in a short-term acute care provider is unresolved. RTI indicates that it will conduct additional research on this issue in its "Phase III." Thereafter, FAH expects that RTI will submit additional findings in its accompanying report. Until there is sufficient data from CMS' own contractor, any conclusion that SSO patients routinely continue the same episode of care that previously began in a short-term acute care provider is grossly premature, and there is absolutely no basis for proposing yet another further restriction to SSO reimbursement.

Moreover, other studies also contradict CMS' presumption and suggest that the episode of care for a given patient admitted to an LTCH is actually quite different than the episode of care of that patient in the short-term acute provider. For example, DRG 475 patients in a short-term acute setting are more often than not discharged from an LTCH as DRG 483 (ventilator patient with trach) following the surgical implant of the trach in the short-term acute provider. This different DRG indicates that there was actually a different episode of care, since DRG 475 is actually used in LTCHs, as well as short-term acute providers.

Based on industry studies, FAH notes that it is generally not true that SSO patients are classified into the same DRG in both short-term and longer term hospital settings. There actually

is very little overlap in the episodes of care for patients in a short-term acute provider and patients in an LTCH, when judged by the DRG classification. One recent industry study indicates that there are only three overlapping DRGs (475- respiratory diagnosis with ventilator, 88 – chronic obstructive pulmonary disease, and 89 – simple pneumonia) in the ten most common DRGs for patients in LTCHs, that are also in the ten most common DRGs for short-term acute patients (who later are discharged to LTCHs immediately following the short-term care discharge). *See* Table 2 to ALTHA Comments to RY 2008 Proposed Rule (March 23, 2007), attached hereto as Exhibit 3. If CMS' assumption were correct that patients in the referring short-term care hospital have the same condition and episode of care in the LTCH, one would expect to see a much closer to one-to-one correlation of cases by DRG within both the LTCH and short-term acute populations. Yet, according to CMS 2005 MedPAR data, there is only a weak correlation between the DRGs of patients admitted to LTCHs and those patients DRGs in short-term acute providers.

Even the primary DRG relied upon by CMS in support of its argument that LTCHs are treating the same episodes of care as short-term care providers actually disproves CMS' presumption. 2005 MedPAR data show only 4,277 short-term acute care hospital patients with a DRG 475 classification that were discharged to LTCHs, but 16,102 patients with a DRG 475 classification that actually were discharged **from** LTCHs. *Id.* This difference is more than 11,000 cases, or 70% of the total. According to the Proposed Rule, these 70% or 11,000 LTCH cases of DRG 475 would be deemed to be part of a single episode of care, first treated in the short-term acute care provider, even though the data completely belie this characterization.

The reason for the great disparity in DRG 475 cases, as well as for many other DRGs, FAH believes, is that these patients who were treated in the short-term acute setting prior to being discharged to an LTCH received a completely different episode of care, as measured by the DRG Grouper software, than such patients actually received when they were admitted to the LTCH. It is far more likely than not, whether based on actual observations, or on characterizations reached using DRG Grouper software, that a single patient who receives care in both long-term and short-term settings will be classified into one DRG in the short-term provider and another in the LTCH, due almost entirely to differences in the type of care provided.

The FAH believes that these differences in the course of care explain much of the disparity in DRG frequencies across the settings. Thus, the data show that there is inadequate basis, if any, for suggesting that short stay LTCH patients continue the same episode of care provided in the short-term acute hospital from which the patient was referred. If a single episode of care were to continue, one would expect to see far more similarity in the frequency of DRG cases between the two types of settings. Instead, the data clearly show one episode of care being completed in the short-term acute care hospital and a second and different episode of care beginning upon admission to the LTCH. Thus, the data do not support basing payment for a short stay LTCH case on the IPPS rate, which was never designed to reimburse care in a long-term care setting.

5. CMS Has Failed To Provide Adequate Notice Of The Regulatory Language CMS Intends To Implement.

CMS proposes a substantive change to its SSO policy in the Preamble to the RY 2008 Proposed LTCH PPS Rule, and then requests comments on this proposed policy. In violation of Section 553(b) of the Administrative Procedures Act, however, CMS offers no specific regulatory language to implement its proposed policy change. The APA, at 5 U.S.C. § 553(b) specifically requires a notice of proposed rule making to include "the terms or substance of the proposed rule." The adequacy of the notice depends on whether the final rule is a "logical outgrowth" of the proposed rule. Kooritzky v. Reich, 17 F.3d 1509, 1513 (D.C. Cir. 1994). Where CMS has not proposed the new regulatory language in the notice of proposed rulemaking, it cannot adopt new regulatory language in its final rule. "Something is not a logical outgrowth of nothing." Kooritzky v. Reich, 17 F.3d 1509, 1513 (D.C. Cir. 1994). In order to comply with the APA notice requirement, CMS must make the language reflecting a substantive change available for comments from interested parties. *See* United Church Board for World Ministries v. Securities and Exchange Commission, 617 F.Supp. 837, 840 (D.C. Cir. 1985) (agency violated the APA notice requirements where it adopted a final rule incorporating a substantive change without including such change in the draft text of the proposed rule and the notice of proposed rulemaking did not discuss the substantive change). "A general request for comments is not adequate notice of a proposed rule change." United Church Board for World Ministries v. Securities and Exchange Commission, 617 F.Supp. 837, 840 (D.C. Cir. 1985).

In the Preamble to its February 1, 2007 Notice of Proposed Rulemaking, CMS discusses its concern as to whether it is appropriate to pay cases that have a covered LOS in the LTCH that is less than or equal to the IPPS ALOS plus one standard deviation for the same DRG more than would be paid under the IPPS for a similar case. 72 Fed.Reg. 4776, 4804-4808 (February 1, 2007). With regard to the SSO payment formula, CMS vaguely suggests replacing the blend option in the adjusted LTCH PPS SSO payment formula, currently codified at 42 C.F.R. §412.529(c)(2)(iv), with an "IPPS comparable" per diem amount, capped at the full IPPS-comparable amount that is used under the blend option of the current SSO policy. 72 Fed.Reg. 4776, 4807 (February 1, 2007). CMS then solicits comments and alternative proposals on how to address its concerns.

The replacement that CMS suggests in the Preamble clearly would constitute a substantive change to the regulations, as it contemplates replacing one method of payment (the blend) with another (the IPPS comparable amount). Accordingly, the new method of payment would necessarily alter 42 C.F.R. §412.529. Later in the notice, CMS states "for the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services would amend 42 C.F.R. chapter IV as set forth below," and goes on to propose specific changes to the language of 42 C.F.R. Part 412. See 72 Fed.Reg. 4776, 4845-4847 (February 1, 2007). CMS does not, however, propose any change to 42 C.F.R. §412.529.

CMS' intent to change the regulation is unclear because whereas the agency discusses a *possible* change in the Preamble, it fails to propose language reflecting any change to the regulations. Although CMS does solicit comments and alternative proposals to address its concerns, such solicitation alone does not provide adequate notice under the APA. Furthermore, CMS' failure to propose any change to the language of 42 C.F.R. §412.529 deprives interested parties of the opportunity to comment meaningfully on such a change. Before issuing a final rule that changes the payment methodology laid out in the current 42 C.F.R. §412.529, CMS must

make the new language available for comment in order to comply with the APA notice requirement.

In addition, courts have consistently held that where notice is less than "clear and to the point," it is legally inadequate and the agency's "consideration of the comments received in response thereto, no matter how careful, cannot cure the defect." *See* McLouth Steel Products Corporation v. Thomas, 267 U.S.App. D.C. 367 (D.C. Cir. 1988) (citing cases) (citations omitted).

FAH contends, therefore, that regardless of whether CMS receives comments on this proposal, CMS is barred from implementing this policy in a final rule until it appropriately publishes adequate notice in the form of substantive regulatory language pursuant to Section 553(b) of the APA and as required by a consistent body of interpretive case law.

6. The Proposed Policy Will Disproportionately Impact Reimbursement For High Acuity DRG Patients With Relatively Long Lengths Of Stay.

Comparing geometric mean lengths of stay for short-term acute patients to the proposed IPPS thresholds that are proposed for use in determining whether LTCH patients will be paid a short-term acute rate show significant differences. Taking into account the 538 DRGs listed in Table 3 of the Proposed Rule, the IPPS threshold is at least double the short-term acute geometric mean length of stay for more than half of the DRGs. In some cases, and affecting various FAH members, the IPPS thresholds associated with several common LTCH DRGs actually exceed (the) 25 days (*average*) needed to qualify a hospital for long-term acute status, and a full 26 DRGs common to LTCH patients have IPPS thresholds in excess of 20 days, a level which should not under any definition be deemed a SSO or VSSO.

FAH believes that these findings undermine the validity of the "one standard deviation" test that CMS proposes using to arrive at the IPPS threshold. CMS' proposal would force LTCHs to accept short-term acute payment for patients that are in an LTCH for lengthy periods of time, even for periods of time which the Congress specifically directed CMS to deem adequate to qualify a hospital for LTCH status. In addition, patients discharged from an LTCH with a ventilator diagnosis are often not admitted into the next level of care, the LTCH, with the same discharge diagnosis from the short-term acute provider. Therefore, it is even more inconsistent to pay the LTCH a short-term rate, based upon a diagnosis that is inconsistent with the discharge diagnosis at the short-term provider.

In the case of several DRGs, the new "IPPS thresholds" are actually greater than the $5/6^{th}$ (of geometric mean LOS – in LTCHs) threshold previously established to determine SSO qualification. One example is DRG 541, which has IPPS and $5/6^{th}$ geometric mean length of stay thresholds of 65.8 and 48.4 days, respectively. CMS has not proposed specific regulations to enact the new IPPS thresholds in this Proposed Rule; however, the Preamble discusses this issue on pages 4806 through 4808 and describes the new short-term acute payment provision as being applicable to "shortest SSO cases (that is, if the LTCH patients cover LOS is less than or equal to the internal 'IPPS comparable threshold')." For cases that exceed the IPPS comparable threshold, "payment ... would continue to be made under the existing SSO policy at 412.529(c)(2)". The Preamble, referenced above, however, is unclear with respect to whether it

is CMS' intent to pay cases that are greater than the 5/6th of the geometric mean length of stay but less than the IPPS threshold, at the normal LTCH PPS rate. In fact, the language appears to suggest almost the opposite.

It is FAH's view that failing to pay the normal LTCH PPS DRG amount for patients that exceed the 5/6th geometric mean length of stay clearly violates the requirements of 42 C.F.R. § 412.529(a). The FAH does not believe there is any justification whatsoever to paying stays exceeding 5/6th of the geometric mean length of stay at less than the full LTCH-DRG, regardless of what the IPPS threshold for that DRG in a short-term acute care facility may be.

If this is not the case, CMS' proposal to limit payment for SSO cases at the IPPS payment rate in all cases would cause all LTCHs to be significantly underpaid, even when by any reasonable standard, the case does not constitute a "SSO" at all. And if CMS is contemplating reducing reimbursement to IPPS levels only for those SSOs below 5/6th of the LTCH geometric mean length of stay that also fall within the average IPPS stay plus one standard deviation (the IPPS threshold), given that CMS has acknowledged SSOs represent 37% of patients served by LTCHs, the new proposal would cause payment amounts to fall substantially below the actual cost of providing care on many cases. FAH members have estimated that the new SSO policy could result in SSO cases being reimbursed at only 57% of the actual cost incurred in caring for these LTCH patients.

Combined with the other LTCH payment changes now recommended by CMS, the impact of the proposed revisions to the SSO payment policy will result in LTCHs being paid significantly less than it costs them to care for appropriately admitted patients. As a result, many patients with complex medical conditions will lose the ability to access needed hospital care, and general acute hospitals will be forced to bear the greatly increased burden of caring for these LTCH appropriate patients and incur additional costs since the general acute care hospitals will be unable to discharge these complex patients to a more appropriate setting.

7. The Goals And Incentives Of The Proposed Change To SSO Reimbursement Policy Are Neither Practical Nor Reasonable.

One might reasonably conclude that CMS' apparent objective is that LTCHs, in the face of declining reimbursement for SSO patients, will choose to decline to admit such patients since the costs of treating the patients will exceed the proposed payment amounts. However, as discussed elsewhere in these comments, LTCHs are unable, almost by definition, to predict a patient's length of stay at the time of admission. Therefore, any policy designed to change LTCHs' behavior in admitting patients by imposing LOS driven payment cuts makes little sense. Instead, LTCHs will simply be forced to absorb payment rates that bear no relationship to the cost of furnishing patient care, and rather than functioning more efficiently, LTCHs will function less efficiently and/or could even be driven out of business. This would deprive patients in need of a valuable source of health care services, and one which Congress has specifically instructed the Medicare program to provide.

Looking at the proposed SSO payment policy, the magnitude of the proposed cuts is so astounding that the proposal appears punitive, as opposed to some type of reasonable incentive designed to improve care. And although apparently aimed at penalizing LTCHs for (in CMS'

view) inappropriately admitting patients who do not need LTCH care, CMS offers no study or analysis accompanying its Proposed Rule demonstrating that inappropriate admissions constitute any material portion of SSO cases. To the contrary, the data presented demonstrates that SSO cases are, for the most part, appropriate for admission to LTCHs.

8. The Proposed SSO Policy Fails To Account For The Portion Of SSO Cases That Unpredictably Die While Admitted To The LTCH.

CMS continues to assume incorrectly the LTCHs can predict accurately in advance the expected length of stay for specific medically complex patients. Physicians who make admission decisions after applying objective and rigorous clinical screening criteria to prospective LTCH patients cannot, and indeed should not, try to predict in advance the length of stay of this group of medically complex, severely ill patients. SSO patients require the same level of care at the outset of an admission as do inlier patients; thus, an LTCH is incapable distinguishing between SSO LTCH patients and inlier LTCH patients at the time of admission.

Data indicate that patients who are ultimately characterized as SSO cases (merely because they leave the facility prior to a certain point) present similar diagnostic mix, similar levels of severity, and similar risks of mortality as compared to inlier patients. Data developed by the LTCH industry suggest consistently that percentages of SSO cases falling into the most common LTCH DRGs are comparable to the percentages of inliers falling into the same DRGs.

In addition, DRG classifications occur after discharge of a patient. Because the $5/6^{th}$ geometric mean length of stay thresholds are different for each DRG, it is clinically impossible to predict whether a patient will be a SSO upon admission.

Moreover, the percentage of SSO patients in LTCHs that exhibit the highest severity of illness and risk of mortality is also consistent with the proportion of inlier patients that fall within these categories. *See* Table 3 of ALTHA comments to RY 2008 Proposed Rule (March 23, 2007), attached hereto as Exhibit 2. Instead of criticizing LTCHs for making admission decisions that after the fact appear imperfect, CMS should be applauding LTCHs for successfully establishing and implementing plans of care to achieve the best clinical outcomes for patients in a shorter than average time frame. Again, for whatever reason, CMS has not chosen to do this.

Clearly, it is inaccurate for CMS to suggest that patients admitted to LTCHs have had shorter stays at acute hospitals than they should have had. In general, most patients admitted to LTCHs already have immediately before had extended stays at short-term acute care hospitals. For example, the average DRG 475 short-term acute care hospital patient has a length of stay of 8 days, but short-term acute patients who are subsequently admitted to LTCHs with DRG 475 first had a length of stay of 27 days, on average, in the **short term** acute care hospital. Overall, moreover, short-term acute patients sent to LTCHs had prior lengths of stay in the short-term acute facility of 13.2 days. This far exceeds the 5.6 day geometric mean length of stay for all short-term acute care patients. Any suggestion by CMS that short-term acute facilities are systematically transferring patients to LTCHs before completing their course of care in the short term facility is completely discredited.

Most FAH member LTCHs also use patient assessment tools, such as Interqual Long-Term Acute Care Criteria (McKesson Health Solutions), to assess the appropriateness of patient admissions, their continued stays and ultimate discharges from each facility. Such criteria are among the standards that MedPAC, itself, has recommended be applied by CMS to define more specifically the level of care furnished by LTCHs, and which are used by many of Medicare's QIOs to evaluate the appropriateness of LTCH admissions. If these standards fail to predict precisely how long a given patient will stay in an LTCH prior to discharge or death, it seems incongruous that CMS would demand that LTCHs must predict length of stay more accurately upon admission. The fact that some patients ultimately require a shorter LTCH stay than average for their diagnosis and clinical complexity does not alter the correctness of the initial admission determination. LTCHs, as do other facilities, give it their best effort and try to accept patients who will benefit from LTCH care.

It is unreasonable, however, for CMS to believe that LTCHs will actively seek to admit patients who are likely to be SSO cases so as to garner some limited financial benefit from treating a shorter length of stay patient. There is no such incentive. If an LTCH fails to apply uniformly screening criteria designed to limit admissions to patients with appropriate lengths of stay, admission of too many SSOs will lower the LTCH's average length of stay and place the LTCH at risk of losing its LTCH certification status due to a failure to maintain the required average length of stay of greater than 25 days. If anything, there is a clear *disincentive* for admitting inappropriate patients to an LTCH.

Coupled with the fact that 2004 MedPAR data suggest that SSO cases are indistinguishable from full stay cases on several important clinical measures, FAH believes that LTCH admitting physicians cannot predictably and consistently distinguish SSO patients from full stay patients on admission. Thus, any incentive for LTCHs to "change their behavior" will fail. Some patients in LTCHs will die while admitted, others may have a shorter course of care than expected. Still others may have a longer course than expected. But to punish LTCHs for failing to recognize outcomes upon admission constitutes both inequitable and misguided policy.

9. The Proposed Changes To SSO Policy Are Inconsistent With The Statutory Definition Of The LTCH Level Of Care.

The statutory definition of an LTCH and the LTCH level of care, itself, are based on the premise that LTCHs treat patients who **on average** and **in the aggregate** have a length of stay of greater than 25 days. In addition, the statutory directive for LTCH PPS, and the entire regulatory framework of the LTCH PPS are based on reimbursing LTCHs for Medicare inpatients who, again on average and in the aggregate, have a length of stay in excess of 25 days. The SSO policy now proposed by CMS facially violates the statutory definition of an LTCH provider and essentially ignores the very foundation on which a PPS system (of any kind) rests.

PPS systems are by design systems based on averages; some patients have longer lengths of stays, some have shorter lengths of stays. Unlike CMS' approach to IPPS, for example, CMS' proposed SSO policy treats SSO cases completely outside of the context of a PPS system. Rather than treating SSOs as part of the average, CMS aims to isolate SSOs as somehow unrepresentative of any group of bona-fide LTCH patients and then to treat only the remainder (essentially those with lengths of stay greater than the average) under a true PPS structure. CMS'

approach -- paying SSOs below cost, **at IPPS, rather than LTCH PPS rates**, violates the notion of a PPS or law of averages system. CMS' view of LTCH PPS is squarely contrary to the will of Congress and CMS' own historical understanding of the legislative intent behind both the IPPS and the LTCH PPS.

In the August 2002 final rulemaking that established the LTCH PPS, CMS stated, in pertinent part:

> 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 hospital inpatient prospective payment system. In a report to 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 [which include LTCHs, among others],' 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 [LTCHs] 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 [LTCHs] could be systematically underpaid if the same DRG system were applied to them.

67 Fed. Reg. 55954, at 55957 (August 20, 2002).

Yet, contrary to CMS' own admission, CMS now expressly intends to systematically underpay LTCHs for SSO cases by paying IPPS rates in violation of Congressional intent and the law of averages on which all PPS systems are based. CMS' proposed SSO policy conflicts with the basic premise that a standard payment is provided for a particular type of case in a particular type of provider, absent extraordinary circumstances. As under any PPS type system, it should be expected that about half of all patients have lengths of stay under the average for a given DRG, and in some cases, significantly below the average. Payment of LTCH PPS rates for these cases is completely consistent with the notion of the law of averages. To the contrary,

dramatically reducing the payment levels for the vast majority of patients whose length of stay is less than average is totally inconsistent with the basic tenets of a PPS structure. Studies have shown that it is also entirely expected that a significant number of LTCH patients will fall below 5/6 of the geometric mean length of stay; this should come as no surprise to CMS. But, equally, this fact is unrelated to the appropriateness of a given patient's admission to an LTCH; it is simply a normal function of the law of averages on which LTCH PPS is based. It is statistically inappropriate for CMS to claim that these "SSOs" are somehow unrepresentative of the ideal of LTCH patients. There are not. Rather, SSOs are a normal and statistically expected portion of LTCH patients whose care should be reimbursed under normal LTCH PPS principles, not as wayward IPPS patients.

10. FAH Recommendations.

CMS, at an absolute minimum, should wait until data is fully available to evaluate the effectiveness of its substantial SSO policy changes from the RY 2007 LTCH PPS Rule before making these additional and largely unsupported changes to SSO policy.

D. Reduction Of Market Basket Increase

1. CMS Proposal.

For RY 2008, CMS proposed a market basket increase from July 1, 2007 to June 30, 2008 of 3.2%. However, after an adjustment to account for what CMS terms an "apparent" increase in case mix in FY 2005 of 2.49%, CMS revises its estimate of the applicable market basket increase and proposes to update the standard federal rate for LTCH PPS providers by only 0.71% for RY 2008. As a result, the federal rate for RY 2008 will be set at $38,356.45, unless it is updated in the Final Rule based on more recent data and/or a recalculation or redefinition of the "apparent" case mix increase that CMS has noted. Pursuant to CMS' statement, the "real" case mix increase is defined as the increase in the average LTC-DRG relative weights resulting from a hospital's treatment of more resource-intensive patients. CMS contends that changes in the case mix for any hospital result from a combination of "real" changes (as defined immediately above) and "apparent" changes (which are defined as increases in the cost mix index due solely to changes by hospitals in coding practices). In order to limit what CMS views as "apparent" changes to the case mix index, CMS has solicited comments at various times with the objective of determining the change in the "real" case mix, as opposed to "apparent" case mix.

2. A 0.7% Increase In The Standard Federal Rate Is Unreasonable And Inadequate.

For several years running, CMS has implemented changes to LTCH PPS in order to slow the growth in new LTCHs and cut back on what CMS believes to be overly robust profit margins. Among these changes were implementation of the existing 25% Rule (not including the current proposal to expand that rule) and "re-weighting" of LTC-DRGs in October 2005, and again in October 2006, which caused a 4.2% reduction in rates following October 2005 and an additional 1.4% reduction in rates following October 2006. In addition, effective July 2006, CMS further reduced payment to short stay outliers by approximately 3.7% and completely

eliminated any increase based on a market basket update for RY 2007 (a reduction of 3.6%!), ostensibly on the basis that apparent case mix increases needed to be offset by a lack of a market basket update.

In the aggregate, these payment changes have reduced LTCH margins close to zero. Based on the changes now proposed for this next year, RY 2008, CMS is proposing rates *below* LTCH providers' actual cost of care! *See* Tables 5 and 6 to ALTHA's comments to Proposed Rule (March 23, 2007), attached hereto as Exhibit 4. Such a proposal is inconsistent with fundamental bases of the Medicare program and the LTCH PPS, which hold that efficiently run providers under PPS should make money or break even, not lose money when providing needed care in an efficient and effective manner.

Yet, in this Proposed Rule, CMS nonetheless proposes yet another VSSO payment reduction, a market basket update reduced to 0.71%, and payments based on inpatient PPS (a draconian cut, on its own) for admissions exceeding 25% from a single referral source, for virtually all LTCHs currently in operation. CMS' contention that payments will still be adequate to reimburse needed LTCH care simply are no longer credible; the payment rates, reduced across the board by so many existing and new factors, are simply inadequate. Industry group studies of LTCH margins for RY 2008 conclude that margins will be negative for this next fiscal year, based on proposed CMS policy.

3. CMS Has Strayed From The Basic Purpose Of The Market Basket Increase – To Account For Expected Increases In Prices For The Upcoming Year.

In focusing almost entirely on "real" versus "apparent" case mix index, CMS has essentially ignored other elements that make up the market basket, such as increases in wages, drugs, products, supplies and other services.

In addition, case mix changes have been adequately considered and addressed during the annual re-weighting of the LTC-DRGs, which CMS has clearly stated will continue on an annual basis. And we applaud CMS for its proposal to ensure that such reweighting is conducted in a budget neutral manner. But case mix has far less to do with specific price inputs that comprise the market basket than do prices of these other products, services and wage levels; thus case mix changes are considered in the annual re-weighting of the LTC-DRGs.

CMS has calculated that price inflation will be 3.2% using the Rehabilitation, Psychiatric, Long-Term Care ("RPL") Market Basket. This is the market basket that was specifically created by CMS only recently to capture the change in prices of items and services that these IPPS-excluded hospital providers purchase to treat Medicare beneficiaries. This market basket update of 3.2% should be applied to the LTCH standard federal rate so that it truly reflects the cost of providing care to Medicare beneficiaries over the next rate year. Yet despite the fact that CMS estimates that input prices will increase by 3.2% over RY 2008, CMS proposes not to update the LTCHs' standard federal rate by anything close to that amount. Simply stated, CMS is proposing to pay LTCHs at a level that does not reflect the current costs of treating Medicare patients. This

is especially troubling given that LTCH Medicare margins have been estimated to be between 0.1% and 1.9% by MedPAC itself, prior to this CMS proposal period,[3] hardly a "robust" level.

The FAH does not understand from the Proposed Rule or any other published account why CMS refuses to follow the RPL market basket, which was specifically designed to reflect input cost structures of three provider types, including LTCHs. Cost inputs in the RPL market basket update include, among others, employee compensation, professional fees, utilities, professional liability insurance, capital related costs, and other products and services such as pharmaceuticals and medical instruments. CMS historically has used price indices such as the Employment Cost Index for wages and salaries and the Producer Price Index for pharmaceuticals to measure how the prices of each cost component change from one year to the next. The market basket is merely the sum of these calculations. Notably, the market basket does **not** measure case mix.

The Medicare program's codified regulations also describe the role of the market basket for LTCH reimbursement at 42 C.F.R. § 412.523(c)(2) and § 412.523(a)(2):

> (c)(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 . . .
>
> (a)(2) update the cost per discharge. CMS applies the increase factor described in (a)(2) of this section to each hospital's cost per discharge determined under paragraph (b) of this section to compute the cost per discharge.

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 LTCH 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 properly explained how case mix changes relate to changes in the price of inputs measured by the market basket update.

The FAH contends on this basis that the proposed reduction to the market basket update based solely on case mix considerations is inappropriate, unwarranted and contrary to existing regulatory requirements. 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 LTCH providers, there is no basis to reduce the market basket update to account for changes in case mix. The FAH believes that a full market basket update of 3.2% is warranted, and required under CMS' own regulatory language.

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[3] MedPAC March Report, p. 220 at: http://www.MedPac.gov/publications/congressional_reports/mar07_ch03.pdf.

4. Changes In "Apparent" Case Mix Have Never Been Verified By CMS Or The LTCH Industry.

CMS has also provided no verifiable data to support its assumption that "apparent" case mix increases are still occurring in the LTCH industry. Based on old data, CMS seems to "assume" that "apparent" case mix increases are present, but offers no data from any current or immediately prior period to suggest that any perceived case mix increases are not real and/or actually experienced by LTCH providers.

The lag in case mix data is particularly relevant in this application. Since so many LTCH reimbursement rules have been tightened over the past couple of years, it seems most unlikely that "apparent" case mix increases are still occurring to any real degree. Thus, without verifiable data to support its assumption of "apparent" case mix increases, CMS is applying an unpredictable method for calculating LTCH market basket increases when reduced by such unverifiable "apparent" case mix increases.

Further, FAH believes that CMS' use of "apparent" case mix increases to offset application of proposed market basket updates to LTCH reimbursement is inconsistent with CMS' proposal to implement budget-neutral LTC-DRG re-weighting. In conjunction with implementation of budget-neutral LTC-DRG re-weighting, CMS has stated that "apparent" case mix increase is no longer an issue, since more recent case mix data is used, which has been re-weighted in a budget-neutral fashion. Given the prior case mix re-weighting performed over the past two fiscal years, and the proposal to implement budget-neutral LTC-DRG re-weighting from this point forward, there is no basis for CMS to claim that "apparent" case mix increases are still occurring and that past increases have not been adjusted. To use a long prior year's estimates (and unverified estimates, at that) of "apparent" case mix increases to offset virtually all of the current year's proposed market basket update, in light of all of the other regulatory changes occurring since the "apparent" case mix increase was purportedly noted, is unsupportable from a policy standpoint, is inconsistent with CMS regulations and is statistically and mathematically questionable.

As it did in the last rate year, CMS also has failed to consider the re-weighting of LTC-DRG rates that occurred earlier this fiscal year. While CMS admits that such re-weighting occurred, CMS has made no effort to gauge the impact such LTC-DRG re-weighting has had on "apparent" case mix increases, if any, in the current or immediately-prior fiscal year. This lack of consideration further renders CMS' offset of the market basket update suspect and potentially invalid.

5. FAH Recommendations.

CMS should apply a full market basket update for RY 2008 of 3.2% to LTCH providers under LTCH PPS.

E. Conclusion

FAH believes that several of CMS' proposed program and payment changes are unnecessary and unsupported by available data. FAH does not believe that extending the "25% Rule" to previously grandfathered hospitals within hospitals and freestanding LTCHs is either

necessary or advisable. Adoption of the proposed changes will significantly interfere with patient choice, the effective and efficient practice of medicine and will disrupt the continuity of care. In addition, extension of the 25% Rule is not required to dissuade early discharges from short term providers to LTCHs; the concerns expressed about early discharges of patients from short term acute providers to LTCHs appear to be exaggerated; and the data do not reveal any pattern of inappropriate early discharges or patient shifting by short term acute hospitals. Moreover, the data clearly demonstrate that patients are receiving different episodes of care in short term acute hospitals and LTCHs. At a minimum, CMS should await further data showing how recent changes to LTCH reimbursement are affecting discharge patterns. Importantly, CMS' proposed policy is also contrary to Congressional intent regarding grandfathered hospitals within hospitals.

Similarly, FAH is deeply concerned and asks CMS to reconsider fundamentally whether its further proposed changes to SSO reimbursement should be adopted. The data are incomplete involving the last set of comprehensive changes that were adopted only last year. FAH believes CMS has not justified implementing yet another restrictive SSO policy, especially where the data show no inappropriate handling of SSO patients and CMS' policy would result in a rate that actually fails, contrary to all Medicare principles, to cover a LTCH's cost of providing efficient care to a long term hospital patient in proven need for such services. Instead, CMS should implement targeted non-payment related approaches such as uniform admission screening criteria, preadmission physician criteria and continued QIO review. Implementation of the proposed SSO policy will only serve to reduce LTCH care available to patients, contrary to the intent of Congress.

Finally, FAH is concerned by CMS' proposed offset of the market basket update for RY 2008 by an alleged "apparent" case mix increase, thereby reducing the actual market basket update to well under one percent. The offset is unsupported by verifiable data, is contrary to the express requirements of existing regulations, and further eliminates the impact of a validly calculated market basket update by incorporating into the market basket calculation a factor (case mix index) that was expressly never made a part of that calculation by CMS' own regulations. To the extent such apparent case mix changes exist, moreover, they have been adequately addressed by other reimbursement changes already placed into effect by CMS.

II. PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION

FAH generally supports the provisions of the February 1, 2007 proposed rule with respect to the direct graduate medical education ("GME") and indirect medical education ("IME") changes and clarifications regarding the claiming of intern and resident full time equivalents ("FTEs") associated with rotations in nonhospital settings.[4] FAH appreciates CMS's efforts in promulgating clarifications and regulatory changes that make it less burdensome for providers to document that they incurred "all or substantially all" of the costs of training residents at a nonhospital setting. In particular, FAH generally agrees that providers should have the option of documenting actual teaching costs or using a proxy as laid out in the proposed rule. Further,

[4] Any reference in the GME/IME section of this letter to a "nonhospital" setting includes also "non-provider" settings.

FAH agrees that incurring 90 percent of training costs should be sufficient under the statutory "all or substantially all" standard. However, as laid out below, FAH requests certain changes or clarifications to the proposals.

A. Modification of the Definition of "All or Substantially All of the Costs"

1. Effective Date and Retroactivity of the Definition of "All or Substantially All."

CMS has expressly sought comments on the effective date of its proposals. FAH strongly believes that providers should get the benefit of the proposals as early as possible and at the same time. This would be the most equitable approach. Thus, FAH recommends that CMS make the proposals effective with portions of any cost reporting periods occurring on or after July 1, 2007. This eliminates the harsh inequity of delaying some providers nearly a year more than others (e.g., a provider with a fiscal year end of May 31 would not get the benefit until its fiscal year ended May 31, 2009 if the proposal is only effective for cost reporting periods beginning on or after July 1, 2007).

Further, FAH strongly believes that substantive regulatory changes must only apply prospectively and cannot legally apply retrospectively. For instance, FAH believes it is quite clear that CMS is changing its interpretation of the statute from requiring payment of 100 percent of resident salaries and fringe benefits to requiring payment of at least 90 percent or resident salaries and fringe benefits. Thus, this is a substantive change to the existing GME and IME regulations and requires a regulatory language change. As such, FAH agrees with CMS's proposal to expressly change the regulatory language to note that only 90 percent of training costs need be incurred. FAH also agrees with CMS's approach to make this substantive change prospective only.

2. Clarification on the Application of the Proxy.

FAH believes that one aspect of CMS's proposal is properly considered a clarification that can and should be available to providers retrospectively for any open cost reporting periods. Specifically, CMS's proposal to allow the use of proxy information (e.g., hours of teaching time and teaching compensation) to help providers document and compute whether and to what extent they have incurred "all or substantially all" of the training costs is a clarification of CMS policy that should apply retroactively. Indeed, CMS has rightfully determined that there need be no regulatory language change to implement the proposed proxy policies.

Significantly, the current proposal is properly viewed as a clarification of prior CMS statements regarding the flexibility providers should have in determining and documenting teaching compensation payment amounts. For instance, CMS has expressly stated that it is up to the parties to the agreement to decide upon the compensation provided. See 63 Fed. Reg. 40954, 40993 (July 31, 1998). In that July 31, 1998 Federal Register, CMS stated that:

> These agreements and amounts paid by the hospital to the nonhospital site may be the product of negotiation between the hospital and nonhospital site. The hospital does not have to report the nonhospital site's GME costs. We anticipate that in the course

> of any negotiation between the hospital and nonhospital site, the nonhospital site may need to identify its training costs. However, this is a matter between the hospital and nonhospital site.

63 Fed. Reg. at 40993 (emphasis added).

This CMS comment comes immediately after CMS indicated that the nonhospital resident counting policy will not establish a "burdensome regulatory structure with tremendous documentation requirements." Id. Further, later on that same page of the Federal Register, CMS clearly acknowledges that there "could be a variety of financial arrangements between hospitals and nonhospital sites with regard to training. The hospital and nonhospital site can take into account those types of arrangements in negotiating an agreement." Id. CMS went on to state that it is "not requiring hospitals to submit cost data to Medicare as a precondition to counting the resident for indirect and direct GME." 63 Fed. Reg. at 40,994.

These CMS statements are entirely consistent with permitting hospitals to use proxies (based on respected, national surveys) for teaching time and teaching compensation. Given how difficult it has been for hospitals to determine nonhospital sites' actual teaching costs, CMS should allow providers the option of using the proxies for any open cost reporting period.

3. Volunteer Teaching Physicians.

FAH fully agrees with and supports CMS's reiteration that teaching physicians can and do volunteer their time to give back to the community and help train residents. The statements made by CMS in this proposed rule appear consistent with prior CMS statements. CMS has indicated that volunteer physicians in solo practices (or their equivalent) do not incur a cost and thus need not be compensated by a hospital for their supervisory teaching activities. In a December 1, 1998 program memorandum, CMS stated:

> For instance, the resident may be training in a physician's private office. In this situation, the physician may receive all compensation through fee-for-service arrangements and may agree to engage in supervising residents without an expectation of additional compensation for teaching. . . . The hospital may count the resident for indirect and direct medical education in this situation if the written agreement indicates that the physician is voluntarily supervising residents and the nonhospital site does not incur graduate medical education.

Program Memorandum A-98-44.

Likewise, CMS indicated in an April 8, 2005 question and answer bulletin posted on the CMS website that:

> Typically, there is a cost for teaching physician time if, for example, the physician receives a predetermined compensation amount for his/her time at the nonhospital site that does not vary with the number of patients he/she treats. In contrast, there is

typically no cost for teaching physician time if the physician's compensation at the nonhospital site is based solely and directly on the number of patients treated and for which he/she bills. The most obvious example of this situation would be a solo practitioner that serves as a nonhospital training site.

CMS Q&A #3.

Importantly, FAH emphasizes and echoes CMS's comment that even certain group practices can include teaching physicians who volunteer, and neither the group nor the individual practitioner would incur teaching costs that need be reimbursed by the hospital. Specifically, FAH agrees with CMS's comment on pages 4821 (third column) to 4822 (first column) in which CMS expressly recognizes that teaching physicians in certain group practices do not receive predetermined compensation for work at a nonhospital site and are thus "functioning as a solo practitioner. . . ." FAH also fully agrees with CMS's statement that such practitioners in a group practice should be presumed to be functioning as solo practitioners with no teaching costs for GME training at the nonhospital site.

B. Implementation of a 90 Percent Cost Threshold

1. Methodology.

As noted above, FAH is supportive of the change to a 90 percent threshold. However, FAH asks CMS to expressly clarify in either the text of the regulation or in the preamble to the final rule that the alternative proxies will not be used by CMS or fiscal intermediaries as a way to disallow a hospital's computation and payment using actual teaching time and teaching costs. In other words, FAH is concerned that the alternative proxies (e.g., three hours per week of teaching and the national average physician salaries) will be used against hospitals as some sort of floor in analyzing the reasonableness of actual costs for those hospitals that choose not to use these alternative proxies. FAH strongly believes that CMS should expressly clarify that the proxies do not establish any sort of floor, or cap, to be used in analyzing whether hospitals that use actual costs have appropriately incurred 90 percent of the training costs. Instead, CMS should clarify that the proxies are available as an option for providers given the difficulty in identifying and documenting actual teaching cost in the nonhospital setting.

2. National Average Physician Salary Data by Specialty.

FAH agrees with CMS that any data used as a proxy for actual physician salaries should be publicly available and free to providers (including the methodology used). However, the American Medical Group Association ("AMGA") charges $450 for access to its annual salary survey. If CMS is inclined to use AMGA data (see comment in the next paragraph, though), FAH urges CMS to make the AMGA data (and all details about AMGA's methodology) publicly available for free on the CMS website. Indeed, because the AMGA survey and its methods are not freely available, providers may not easily be able to analyze and concur with AMGA's methodology or the amounts set forth in Table 7 on pages 4823 and 4824 of the Federal Register.

For IME and GME proxy purposes, FAH requests that CMS use the reasonable compensation equivalent ("RCE") amounts instead of the AMGA salary data. FAH believes that

CMS has consistently relied upon the RCE amounts as reasonable compensation figures that are used to limit Medicare reimbursement for hospital-based physicians in a variety of specialties. The RCE amounts and methodology are well known in the provider community and have been used by CMS since the 1980s. Further, the RCE amounts are already slightly modified for geography (i.e., for metropolitan areas greater than 1,000,000, non-metropolitan areas, and metropolitan areas less than 1,000,000). FAH believes that if the RCE amounts are an appropriate proxy for limiting hospital-based physician compensation then they should likewise provide an appropriate substitute for teaching physician compensation for IME and GME proxy purposes. As stated in the March 2, 1983 Federal Register, CMS "estimated the national average (mean) income for all physicians using 1979 physician net incomes form the American Medical Association (AMA) Periodic Survey of Physicians (PSP) . . . ." 42 Fed. Reg. at 8919 (March 2, 1983). Further, in that Federal Register, CMS indicated that the "universe sampled by PSP *included* both office-based and hospital-based physicians and excluded *only* those physicians who are full-time salaried employees of institutions." Id. Thus, FAH maintains that updated RCE amounts are an appropriate proxy for teaching physician compensation and their use would have the added benefit of consistency.

C. Other Issues to Be Considered/Written Agreements

In the "other issues" section of the proposed rule (page 4828), CMS reiterates that providers who choose not to make concurrent payments to the nonhospital site will still be required to enter into written agreements with the nonhospital site "before the hospital may begin to count residents training at a nonhospital site . . ." FAH is very concerned about the timing associated with entering into new written agreements that would lay out specific teaching compensation using the alternative proxies. For instance, if a hospital chooses the alternative proxies and compensation amounts must be expressly laid out in the written agreements, then it will be nearly impossible to enter into multiple (sometimes hundreds, depending on the size of the programs) new written agreements in advance of rotations that would start as of July 1, 2007. This is especially true given that CMS's proposals might be changed slightly or dramatically based on comments received and might not even be finalized until a final rule is published in May or June (or even in July after the next academic year begins).

Thus, FAH urges CMS to impose a one year transition or grace period pursuant to which written agreements can be amended or newly executed at any time prior to June 30, 2008 and still be effective for any and all portions of the academic year starting July 1, 2007. Under such a transition or grace period, intermediaries would not disallow FTEs solely because a written agreement was dated and executed after the rotation occurred so long as it was executed on or before June 30, 2008 (for rotations occurring between July 1, 2007 and June 30, 2008).

Such a transition (or grace period) will allow hospitals the time to: 1. determine whether to use the proxies, actual data, or some combination of proxy and actual data, 2. determine the numbers of supervising physicians and residents for each program at each site in order to determine actual ratios or use of the 1:1 presumptive ratio, 3. determine the opening hours of each nonhospital site, 4. negotiate actual or proxy amounts with nonhospital sites, 5. draft either new agreements or amendments to existing agreements, and 6. secure the necessary signatures (which, again, could be many dozens or even hundreds of signatures). FAH believes it would be quite reasonable and appropriate to allow providers one year to adjust to the proxy alternative

and work in their choices into written agreements (as necessary) over the course of the upcoming academic year. Such a transition or grace period with respect to the timing of the written agreements will not impact in any way the requirement that hospitals actually incur 90 percent of the training costs (as defined in the new 42 C.F.R. § 413.75(b)(2)). Further, allowing the transition or grace period would still afford intermediaries with fully executed written agreements for use during their audits.

If CMS is not inclined to provide a one year transition or grace period solely with respect to the timing of the written agreements, then FAH alternatively requests a 180 day transition or grace period through to December 31, 2007. Again, under such a transition or grace period, intermediaries would not disallow FTEs solely because a written agreement was dated and executed after the rotation occurred so long as it was executed on or before December 31, 2007 (for rotations occurring between July 1 and December 31, 2007).

FAH certainly hopes that CMS will adopt a one year (or at least a six month) transition or grace period as laid out above. However, if CMS is not inclined to offer any transition or grace period, then FAH requests that CMS relax the requirement to specifically set forth the precise teaching compensation amount in the written agreements for at least the next academic year. Again, it will be very difficult to amend the compensation amounts using the proxies prior to rotations that will start as soon as July 1, 2007. Instead, FAH proposes that CMS allow hospitals to execute a simple addendum to existing agreements (or include a simple provision in new agreements) that states: "the hospital will pay the nonhospital site teaching compensation amounts consistent with the definition at 42 C.F.R. Section 413.75(b)(2) and accompanying guidance from CMS in the Federal Register." Again, such relief will not impact hospitals' requirement to actually incur the requisite training costs.

Indeed, with or without any of the temporary relief requested above, FAH suggests that CMS reconsider, in general, its strict requirement that the actual amount of teaching compensation be set forth in the written agreements. Hospitals that make concurrent payments are held to the regulatory standard and audited by intermediaries without any written agreement. Thus, it should not be any more difficult for intermediaries to audit hospitals that choose the written agreement approach even if those written agreements are not precise with respect to the amount of teaching compensation. Since the agreements appear to be required in advance of the rotation (which FAH generally does not believe is a useful or necessary requirement), it is often quite difficult to predict exactly how much a nonhospital site will incur in teaching costs. Thus, it would be more accurate and make sense to either allow generally for written agreements to be executed during or shortly after rotations and/or to allow the written agreements to be more general about the teaching compensation amounts to be paid. Significantly, CMS's current requirement to precisely set forth the teaching compensation in the written agreement runs contrary to the notion of making the nonhospital rotation process less administratively burdensome. This is because CMS's current requirement would require annual amendments to most of the written agreements to account for even the most minor changes in teaching costs (e.g., due to cost of living increases in faculty salaries). This type of precision simply should not be necessary in the agreement itself so long as the hospital can document during the audit process that it incurred 90 percent of the training costs at the nonhospital site. FAH requests that CMS expressly offer some specific flexibility on setting forth the compensation amount in the written agreements.

Even if CMS is not inclined to allow more general commitments regarding the teaching physician payments in lieu of precise dollar amounts in the written agreements, FAH urges CMS to at least indicate that the ultimate amounts paid can vary from the amounts set forth in the written agreements. Again, it is quite difficult to know in advance of rotations the precise, ultimate teaching costs at the nonhospital setting. Among other things, the ratio of teaching physicians to residents may change, the compensation paid to physicians may change, and/or the number of residents on rotation might change. Thus, it is important for hospitals to know that they can pay the nonhospital site based on 90 percent of the actual training costs despite the amounts set forth in the written agreements, which were based on good faith, best efforts to predict such amounts prior to the academic year or the rotations.

Finally, at the top of the middle column of page 4829, CMS has noted that separate computations of training costs must be made for each specialty program at a given nonhospital site. FAH requests that CMS provide either a clarification or preferably a detailed example demonstrating how to apply the various proposed proxy variables when a hospital sends residents in two or more specialty programs to the same nonhospital site. In particular, FAH is interested in a clarification on how to make the separate computations when the different specialty programs operate at the nonhospital site for a different number of hours per week (e.g., internal medicine for 15 hours per week and family practice for 25 hours per week; and the nonhospital site is open for a total of 40 hours per week).

D. Proposed Regulatory Text

FAH notes (and supports) that CMS has made it clear in proposed sections 413.75(b)(2), 413.78(f)(2) and 413.78(f)(3)(ii) that a hospital need only incur 90 percent of the training costs. FAH believes that although not expressly reiterated, the 90 percent threshold clearly applies to the requirement in section 413.78(f)(3)(i), given that CMS is using the phrase "all or substantially all of the costs for the training program" which is defined at section 413.75(b)(2).

III. CONCLUSION

FAH appreciates this opportunity to comment on the Proposed Rule. FAH stands ready to work with CMS in assessing how to produce meaningful regulation based on verifiable data that will fairly adjust costs and payments, but which will also protect LTCH-level patients' access to care in LTCH facilities in their local communities. If you have any questions, please feel free to contact me or Steve Speil, Senior Vice President, at (202) 624-1529 or sspeil@fah.org.

Respectfully submitted

Table 1

2005 MedPAR STACH Discharges			DRG Type	
Payment Type	**Total**		**Post Acute**	**Non-Post Acute**
All Discharges				
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%
Discharges to LTACH				
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%
Discharges to Other Destinations				
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				

EXHIBIT 1

Table 3

DRG	DRG Description	STACH ALOS	STACH SOI 3 & 4%	LTACH ALOS	LTACH SOI 3 & 4%	VSSO ALOS	VSSO SOI 3 & 4%
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	13.9	96%	38.3	94%	10.1	94%
271	SKIN ULCERS	11.8	43%	29	74%	7.8	74%
87	PULMONARY EDEMA & RESPIRATORY FAILURE	7.7	72%	29	91%	6.7	87%
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	8.5	62%	23.9	79%	8.7	73%
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	5	26%	20.6	60%	5.4	51%
249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	10.2	10%	25.1	41%	6.2	28%
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	5.6	44%	21	75%	5.5	70%
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	6.1	24%	28.5	49%	9.3	43%
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	17.5	17%	22.7	54%	10.3	43%
462	REHABILITATION	12.4	36%	22.6	52%	11.6	45%

EXHIBIT 2

Table 2

LTACH Rank	DRG	DRG Description	LTACH PPS Frequency	IPPS Frequency	IPPS Discharge to LTACH Rank
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
		Total	**136,226**	**112,163**	

EXHIBIT 3

Table 5

RY 2008	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 [x] shows that the cumulative effect of changes in LTACH PPS is to reduce reimbursement below even the lowest estimate of costs.

Table 6

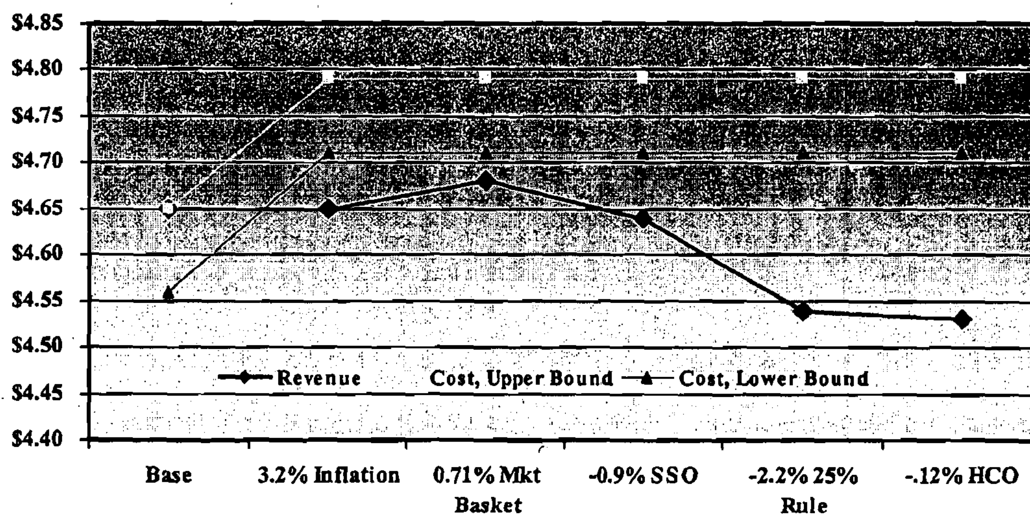

EXHIBIT 4

Chart 7

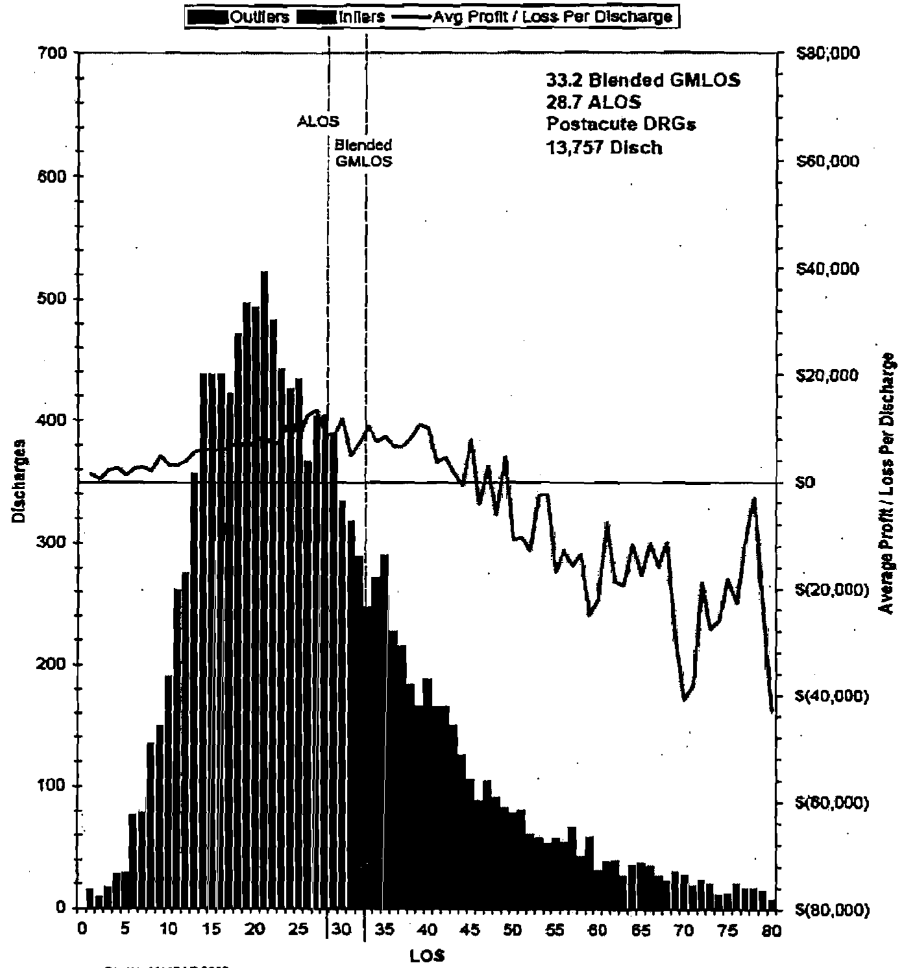

EXHIBIT 5

1028589.1

Chart 8

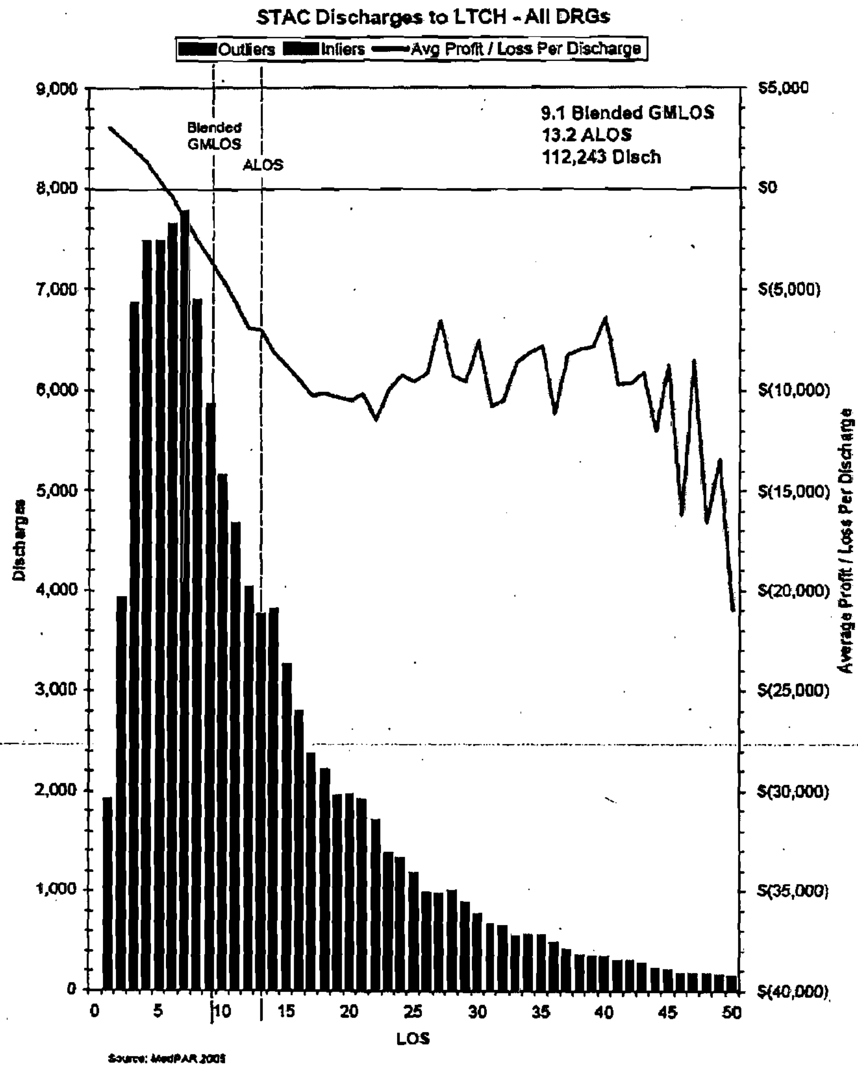

EXHIBIT 5

1028589.1

Chart 9

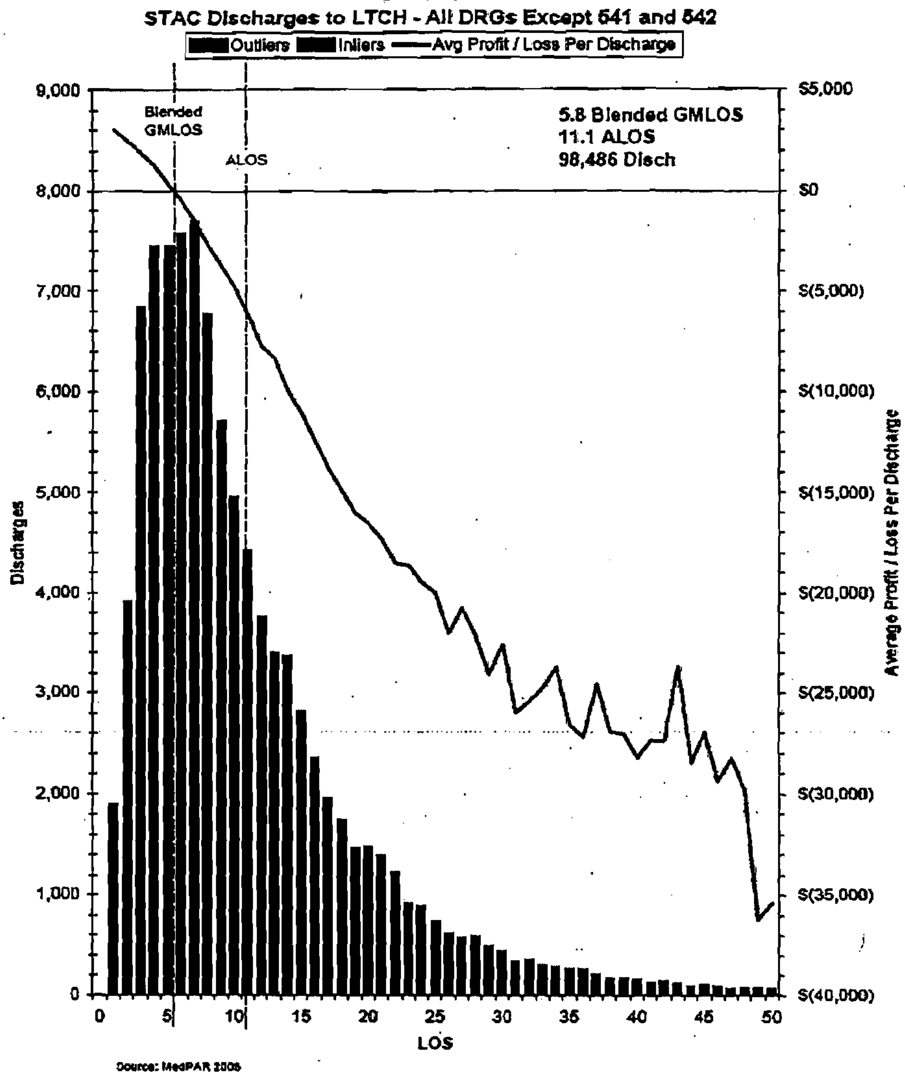

EXHIBIT 5

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Vinson&Elkins

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March 26, 2007

Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
Attention: CMS–1529–P
P.O. Box 8015
Baltimore, MD 21244–8015.

Attention: Renate Rockwell

Re: File – CMS–1529–P
Comments on GME Portion of Rule

Dear Sir or Madam:

These comments are submitted on behalf of two health systems in Wayne County, Michigan who participate in GME programs: Henry Ford Health System and Oakwood Healthcare, Inc.

GENERAL

Resident rotations to nonhospital sites are common. Some rotations to the same site may extend for all years of the residency program, but other rotations may be for a very short time. Even small residency programs may deal with several dozens of nonhospital sites. Teaching hospitals face a huge burden in attempting to comply with CMS's existing policy on counting residents rotating to nonhospital settings, as set forth in April 2005. The proposed rule is a welcome step to simplifying this complex area. We commend CMS for moving toward administrative simplification. As CMS considers comments and moves toward a final rule, we hope that CMS continues to keep in mind and work toward its stated goal of simplifying compliance with the regulation on residents rotating to nonhospital sites.

DEFINITION OF "SUBSTANTIALLY ALL"

CMS proposes to modify its definition of "all or substantially all of the costs of the training program in the nonhospital setting" to encompass 90% or more of the training program's costs. 72 Fed. Reg. 4776, 4820 (Feb. 1, 2007). CMS states in the proposed rule that "industry representatives" define "substantially all" as being 90% or greater, yet provide no evidence to support its statement. It is critically important that the rulemaking record include the evidence supporting statements of this ilk. As the trade association representing teaching hospitals, which is aware of common, accepted definitions, standards, and practices among teaching hospitals and hospitals generally, AAMC has no awareness of "substantially all" being defined by hospitals or anyone else as 90 percent. Indeed, CMS, itself, has defined "substantially all" as 75 percent in a closely related regulation.

CMS has defined "substantially all" as 75% in the context of financial relationships between physicians and entities furnishing designated health services—the "Stark" provisions. 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, requires that each physician member of a group practice must furnish "substantially the full range of services which the physician routinely provides" on an individual basis and that a group practice is an association "for which substantially all of the services" of group member physicians are furnished through the group "and are billed in the name of the group." 42 U.S.C. § 1395nn(h)(4)(A), (B). In interpreting the statute, CMS stated in its initial proposed rule that "the word 'substantial' generally means a considerable amount," and that 85 percent would constitute "substantially all" of an amount. 57 Fed. Reg. 8588 (Mar. 11, 1992). Later, CMS lowered the threshold for "substantially all" to 75 percent, a standard which remains in effect today. 42 C.F.R. § 411.352(d); 60 Fed. Reg. 41914, 41931 (Aug. 14, 1995); 66 Fed. Reg. 856, 904, (Jan. 4, 2001).

It is a standard rule of interpretation that the same term should be defined the same way within a single statutory scheme. CMS has already interpreted "substantially all" in the context of the Social Security Act as meaning 75 percent (and notably started at 85 percent, lower than the 90 percent proposal in this instance). Indeed, the issues are very close since both laws focus on physician practices—in the nonprovider site statute, Congress refers to the costs of a *physician practice*; in the Stark law, Congress refers to the services of a *physician practice.* There is no reason on the face of the law or in underlying policy reasons

to interpret "substantially all" differently in the nonprovider site context than for Stark purposes.

Courts have also defined "substantially all" as being 75% 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% of its total assets was a sale of "substantially all" of its assets. 199 A.2d 557, 562 (1964).

Given CMS's and the courts' interpretations of the term "substantially all" as being 75% or greater, the 90% threshold proposed by CMS in the GME rule is too high. We recommend that CMS adjust the threshold to 75%, as is its current practice.

Although the issue did not arise in the proposed rule, the record should clearly state that nonhospital sites have no overhead relating to residents. These sites are physician offices and clinics are designed solely for patient care. Residents are not taking up any space that is not otherwise used and account for no additional space-related costs. Residents are seeing patients of the nonhospital site, patients who would be seen whether or not the residents were there. In any event, patient care costs are not teaching costs, as CMS has reiterated on several occasions. Accordingly, there are no overhead costs relating to the training of residents at these sites.

EFFECTIVE DATE OF JULY 1

The effective date should be July 1, 2007 without regard to cost reporting periods. The academic year begins July 1 and agreements relating to residency programs often become effective date on July 1. In addition, when CMS changed its interpretation to require hospital payment for the costs of teaching physicians, the change was effective January 1, 1999 without regard to hospital cost reporting periods. Similarly, when CMS eliminated the requirement for written agreements for residents rotating to nonhospital sites as long as payment of the costs of such rotations was made within three months of the month of the rotation, CMS made the change effective on October 1, 2004 without regard to cost reporting periods. CMS should be consistent with its past practice and make this change effective on July 1, 2007 without regard to cost reporting periods.

THREE-HOUR PRESUMPTION

The nature of training at nonhospital 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. It is our experience that there is not as much as three hours of teaching time in nonhospital sites. Indeed, we believe that at many sites that all the teaching occurs within the context of patient care encounters and that the only teaching time, as defined by CMS, is for completing the resident evaluation, which is *de minimis.* To simplify dealing with these situations, we recommend that CMS accept attestations that the only teaching time, as defined by CMS, in a resident's entire nonhospital rotation was for the resident evaluation and that it took a half hour or less.

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 nonhospital 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 nonhospital 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 nonhospital sites to compute the costs of that teaching. The preamble to the 1998 rulemaking indicated that whatever reasonable amount was agreed upon by the nonhospital site and the hospital would be accepted as reflecting the costs of the nonhospital 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 nonhospital 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 nonhospital 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.

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 nonhospital 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 nonhospital 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 nonhospital sites that is 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.

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

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

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

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 nonhospital 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, 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:

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

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

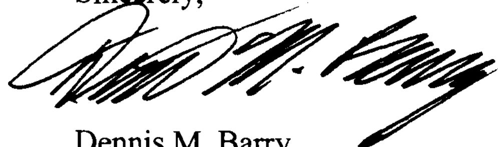
CMS has repeatedly referred to "travel and lodging" expenses in its regulation. We have no objection, in principle, to counting those items as costs. The teaching hospital community presumes, however, that CMS is referring to "travel and lodging" expenses as those terms are usually understood. Hospitals 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 nonhospital 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.

Finally, there are vacations when a resident opts to do a nonhospital rotation at a site which is convenient to the resident's home. The rotation has educational value and is part of the approved program; however, rotations of equal educational value were available to the resident in the home community of the sponsoring institution. Permitting the resident to rotate to a nonhospital site close to the resident's home is an accommodation to the resident and yields no incremental educational benefit, and no incremental benefit at all to the hospital paying the resident. Since these are not the type of travel and lodging expenses that ordinarily would be reimbursed by employers, these should not be viewed as a "cost"

associated with the residency program. In these instances, we believe that CMS should make clear that the hospital does not need to bear the costs of the resident's travel and lodging.

Sincerely,



Dennis M. Barry

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March 15, 2007

Ms. Leslie V. Norwalk, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
P.O. Box 8011
Attn: CMS – 1529-P
Baltimore, Maryland 21244-8015

RE: CMS – 1529-P

Dear Ms. Norwalk:

RML Specialty Hospital (RML) is pleased to have the opportunity to present comments on the Medicare Program; Prospective Payment System for Long Term Care Hospitals RY2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes.

By way of background, RML is a freestanding hospital licensed in the State of Illinois and is recognized by Medicare as a long term acute care hospital (LTCH). RML is a 501(c)(3) not-for-profit limited partnership, whose members are Rush University Medical Center and Loyola University Medical Center. RML's clinical focus is on ventilator weaning (respiratory), complex medical, and wound services. Because of these programs, RML has historically maintained one of the highest case mix levels among any LTCH in the country. During the last 12 months, our overall case mix index fluctuated between 1.58 and 1.8 for Medicare patients. This is even after the drop in case mix levels that impacted the LTCH industry effective October 1, 2006. Patients treated at RML are referred from approximately 65 hospitals in Illinois. Our patients primarily come from ICUs, critical care units, burn units, and step down units.

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

1. **LTC-DRG Classifications and Relative Weights** – In Subsection C of this section, CMS notes that it is expecting to "quickly" complete the evaluation of alternative DRG systems for use under the IPPS as part of moving forward on adopting a revised DRG system that better recognizes severity in the IPPS.

   If CMS implements a new system in FY2008, should the LTCH industry assume that this new, but as yet unidentified methodology, will be implemented into the LTC-PPS at the same time? This question arises because the IPPS methodology is used in the LTC-PPS system to determine certain payment levels. Is it likely that a new severity-based methodology will be implemented as soon as October 2007 or is it more likely a new system would be established for some specified date in the near future?

2. **Proposed Budget Neutrality (BN) Requirement for the Annual LTC-DRG Update** – I would like to take this opportunity to thank CMS for proposing that the LTC-PPS updates be done in a budget neutral manner. This would include the annual updates to the LTC-DRG classifications and relative weights such that the estimated aggregate LTC-PPS payments would be unaffected.

   It is noted in this section that CMS is proposing to utilize a "similar methodology" used in the IPPS system. It is also noted in the CMS narrative that updating the LTC-DRGs in a budget neutral manner would result in annual updates to the individual LTC-DRG classifications and relative weights based on the most recent available data to reflect changes and relative LTCH resource use.

   It then goes on to say, however, the LTC-DRG relative weights would be uniformly adjusted to insure that estimated aggregate payments under the LTC-PPS would not be affected. (That is, decrease or increase.) The way this is written, it suggests there will be no annual increase for such things as a market basket adjustment under this methodology. Please clarify that the budget neutrality adjustment is independent of annual market basket changes.

3. **Proposed Changes to the LTCH-PPS Payment Rates for the 2008 LTCH-PPS Rate Year** – I applaud CMS's proposed adjustment to increase the standard federal rate by .71%. Based on the changes made by CMS last fiscal year, the .71% increase is necessary to cover some of the significant expense increases that LTCH's have had to incur this year. This modest increase is necessary since expenses continue to increase annually.

   CMS requested comments on the possibility of having a 0% update of the Standard Federal Rate for RY2008. From a provider's perspective, the .71% is appreciated, but still not adequate. The modifications that were made by CMS last year to the short stay outlier payment methodology (in July 2006) and then the subsequent changes in the case weights (in October 2006) have had a dramatic negative impact on the financial "profitability" of LTCHs. Short stay outlier and high cost outlier cases now have significant negative operating margins and aggregate margins are dropping to dangerous levels. LTCHs are now struggling to cover annual increases in expenses and to meet capital reinvestment needs.

4. **Proposed Adjustment for High Cost Outliers** – CMS is suggesting an increase in the fixed loss amount to $18,774, which is a 26% increase over the current fixed loss amount. Although CMS identifies that the fixed loss amount in previous years was set at higher levels than the proposed RY2008 fixed loss amount, the consequences from the case weight changes in October 2006, and other changes implemented in July 2006 (short stay outlier changes) have not been reflected in CMS's going forward assumptions. If RML's experience is reflective of the entire LTCH industry, then the significant drop in case weights in October must have had a material impact (i.e., lower spending on LTCHs by CMS) on both an aggregate level and more specifically on outlier payments. I encourage CMS to delay any proposed increase in the high cost outlier fixed loss amount until October 2007 at the earliest. This would allow CMS to fully identify the already achieved spending reductions from the FY2007 LTC-PPS adjustments before making any additional changes.

5. **One-Time Prospective Adjustment to the Standard Federal Rate** – CMS again defers its decision to make a one-time adjustment in the federal base rate until July 1, 2008.

   I strongly suggest that CMS reconsider its decision to delay this for another year (until July 2008) and eliminate it from present and future consideration. CMS should state that there would not be a future one-time adjustment to the LTC-PPS system. If CMS believes that an adjustment may still be required, then at a minimum, CMS should agree to include as "offsets," all of the significant changes that have been implemented by CMS since the start of the LTC-PPS.

6. **Short Stay Outlier Policy** – The proposed short stay outlier modifications will make it very difficult for LTCHs to adequately and appropriately quantify the reimbursement for patients that fall within the short stay category. RML does not support any further modification of the SSO payment methodology. If CMS does continue with this proposal, then there are several significant problems that must be addressed prior to its implementation.

   a. IPPS lengths of stay are based on IPPS discharges, not on the lengths of stay associated with LTCH patients. It appears as if CMS's underlying assumption is that patients that have short stays in LTCHs should be comparable to patients coded into the same DRG at short stay hospitals. There are fundamental differences in the assumptions used to determine the corresponding lengths of stay, case weights, case volumes, etc., between the short stay and long term venues. As an example, DRG-565 or DRG-566 are used for ventilator patients. Ventilator patients in short term and long term settings are not the same. Patients coded to these DRGs in the short stay arena have typically been trached and on a ventilator and most likely have had an incident that has exacerbated their condition, which necessitated an admission. A DRG-565/566 LTCH patient is typically coming from an acute facility immediately post-trach and usually has many complications. It seems inappropriate to mix the assumptions between the two venues.

      This proposal would mix "apples and oranges." A patient admitted into an LTCH would more than likely have a different DRG associated with its stay than at the short stay hospital. As an example, DRG-483 is often the predecessor DRG to a ventilator patient being admitted into the LTCH. DRG-566 (which could be the LTCH admission DRG) would have a different case weight and lengths of stay in the IPPS than the LTC-PPS. The patient level characteristics between the 2 venues are significantly different. By using a standard deviation from one system to gauge a length of stay in another system is inappropriate.

   b. CMS points out that a large percentage of short stay outliers have a length of stay of 14-days or less. If this is the case, then I strongly suggest that instead of coming up with a payment methodology that is not manageable, CMS should first determine which patients should go to an LTCH versus patients that should stay in the short stay environment. One suggestion would be to set an admission requirement that LTCHs can only admit patients directly from short stay hospitals. Having a requirement like this could enhance the integrity of both

systems. Under this method, if there is a direct admission into an LTCH from a non-hospital setting, then CMS would reimburse the LTCH using the IPPS reimbursement system for that patient. If 20% of LTCH patients are admitted from non-short stay hospital settings, then this requirement should provide savings to the Medicare system.

c. The new proposed short stay outlier methodology would create a "double cliff" for providers trying to manage patients. This means there would be a cliff at the IPPS DRG length of stay plus one standard deviation, then another cliff at the 5/6th geometric length of stay under the LTC- PPS. Additionally, this new methodology could conflict with the 5/6th LTCH DRG geometric length of stay. This creates the potential for providers to manage lengths of stay, as opposed to the clinical needs of the patient.
d. The recent RTI study does not reflect the reimbursement impacts from CMS' July 1, 2006 SSO payment policy change. It would be inappropriate to recommend further payment reductions without first understanding and analyzing the reimbursement impact from this change.
e. The current RTI study's key focus is to determine the appropriate setting for IPPS discharges. This study will have a substantial impact on all post acute healthcare providers. RML requests CMS to allow RTI to complete its study and corresponding recommendations before CMS makes further SSO payment reductions.
f. CMS has stated there are too many SSO cases discharged from LTCHs. To date, LTCH providers have been unable to predict the admissions that would discharge as a SSO. Please comment on how CMS believes LTCH providers should be able to screen out SSO cases prior to admission. Also, please comment on why the current IPPS transfer rule does not appropriately adjust for payment when cases ultimately become SSO discharges in the LTCH setting.
g. The LTCH PPS payment rules are by far the most complex of all provider reimbursement rules. The added complexity of the SSO payment methodology under consideration by CMS only further exacerbates this difficult situation. RML recommends CMS take into consideration the administrative burden and increased costs incurred by providers to program information systems and train personnel when making highly complex payment formula modifications. CMS needs to keep in mind that many third party Medicare supplemental payers structure policies to pay the same as Medicare and most of these insurers do not have either the capabilities nor incentive to accurately program their systems and train personnel to keep up with the pace of these complex changes being implemented by CMS.

7. **The 25% Rule – Expansion of the Special Payment Provisions for LTCH Hospitals-within-Hospitals and LTCH Satellites** – The implementation of the 25% Rule to all LTCHs is an attempt by CMS to stop the growth and further expansion of this industry. RML is not impacted by this proposed rule. RML's largest referral source accounts for only 14% of our annual admissions. An alternative to this proposed methodology would be for CMS to establish "site of service" differentials for LTCHs that would accomplish CMS's goal without having to implement a 25% admission rule. There could be site of service differentials for hospitals-within-hospitals (and their successor organizations), satellites, grand fathered hospitals, or other CMS-identified providers. These sites of service differentials would establish

different rates based on the "structural" differences between these types of LTCH providers. Or, there could be payment differentiation between high acuity providers and low acuity providers, which could recognize the resource intensity differences between LTCHs.

As an alternative to the 25% rule, CMS should consider implementing a "moratorium" on the industry for a period of 3-5 years. This timeframe would allow the RTI study to continue, it would freeze the number of current LTCHs (which would provide Medicare with significant savings, and it would also allow CMS to further determine the impact of prior changes.

8. **Computing the Federal Prospective Payments for the 2008 LTCH-PPS Rate Year** – Could CMS provide an example (using the Chicago area) that would depict the different methodologies associated with the proposed short stay outlier computation?

9. **Regulatory Impact Analysis** – I believe the savings magnitude of the implementation of the 25% Rule is grossly understated. If only 12% of existing LTCHs meet the 25% Rule, then the remaining 88% of LTCHs would have to adjust their admissions in order to meet the new requirement. It appears as if there is a high likelihood that hospitals-within-hospitals, grand fathered hospitals, and newer hospitals that were built to replace HIHs, are not going to meet this 25% rule requirement. If this is the case, a significant portion of these patients would end up staying in short stay hospitals, which more than likely would result in additional reimbursement for short stay hospitals. In cases where the short stay hospital receives a fixed payment, then the expense of additional days becomes an added financial burden to the short stay hospitals. From a practical standpoint, most LTCH organizations will not be able to significantly modify their admission practices and behaviors to work within this 25% rule constraint.

10. **Long Term Care Hospital (LTCH) Payment System Refinement/ Evaluation Conducted by RTI and Their Corresponding Recommendations** – It is surprising that after the amount of time CMS studied the RTI Phase I Study recommendations that more of the recommendations are not being suggested for implementation by CMS. Specifically, I would like to address two of the recommendations and provide input.

    The first recommendation relates to standardizing conditions of participation and setting staffing requirements for treating medically complex patients. The first part of this recommendation is appropriate, but the second part is inappropriate. In no other setting does CMS mandate staffing levels. Staffing levels should be based on meeting the clinical needs of the patient that a particular institution is serving.

    The recommendation from RTI that would allow LTCHs to develop rehabilitation and/or psychiatric units should be implemented as soon as possible.

CMS requested input on other concepts and ideas. As I have suggested in previous comments, I believe CMS still has an opportunity to create "Centers of Excellence" within the LTCH arena similar to open heart and transplant programs. I suggest that "ventilator" designations could be used for programs that have 100 or more annual ventilator admissions. This ventilator designation could be used to better identify the types of patients that would be appropriate for an LTCH admission.

An additional concept that I have put forward in previous comments is the request for CMS to evaluate the possibility of providing an "add on" payment to LTCHs that serve high levels of dialysis patients. CMS could utilize the same 10% threshold requirement that is available to short stay hospitals. I strongly encourage CMS to extend this same methodology to the LTC-PPS system.

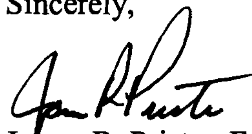
CMS should also reconsider having updates 2-times per year for LTCHs. Although there is a belief that LTCHs are nimble, the reality is that the twice a year changes creates a significant burden on relatively small providers. One adjustment per year should become the norm for LTCHs.

As a concerned participant of the LTCH industry, I strongly encourage CMS and other related units within the federal government to continue focusing on and dealing with LTCHs that do not meet the current 25-day length of stay requirement. It appears as if very little has been done to enforce this requirement, and I strongly encourage CMS to enhance its efforts at preventing this situation from continuing in the future.

I appreciate the opportunity to comment on the proposed rule and CMS' willingness to request input from providers. RML is available to work with CMS to explore these issues in more detail.

If we can be of any assistance, please don't hesitate to call upon us. I can be reached at 630-286-4120.

Sincerely,



James R. Prister, FACHE
President/CEO

cc: Brian Peterson, Representative Judy Biggert's Office
Scott Ziomek, MCHC

JRP/dmg

Edmond Specialty Hospital

March 14, 2007

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

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

Dear Ms. Norwalk:

Edmond Specialty Hospital submits these comments on proposed rules published in the above referenced Federal Register.

Edmond Specialty Hospital is a long-term care hospital (LTCH) established in 1991, and is located in Edmond, Oklahoma. Edmond has a population of approximately 75,000, and has only one acute care hospital, Edmond Medical Center, located within the community.

For the past 16 years Edmond Specialty Hospital has provided LTCH services to the citizens of Edmond and the surrounding area. Many of our patients have received general acute care services at the local community hospital because people want to be treated in their home town hospitals. CMS's expansion of the 25% rule to include freestanding LTCHs fails to recognize the many localities, such as Edmond, in which LTCHs serve local, acute care hospitals therefore making it impossible to satisfy the 25% rule. Expanding the 25% rule will require patients from Edmond to be virtually "bused" out of their community to obtain LTCH services, and will not only jeopardize their access to appropriate medical care, but will create a significant financial hardship for our hospital.

Edmond Specialty Hospital questions the basis of the 25% threshold. CMS has presented no evidence to show that there is any statistical basis for applying such an arbitrary rule other than to penalize LTCHs. If CMS is concerned with the growth of long term hospitals, establishing uniform admitting criteria and implementing a moratorium on new LTCHs would more appropriately address these concerns.

1100 E. Ninth Street • Edmond, OK 73034 • Phone (405) 341-8150 • Fax (405) 715-2259

I also want to express my strong opposition to the proposed extreme short-stay outlier (SSO) policy. The proposed rule is an unprecedented intrusion on physician decision making and contrary to long standing Medicare principles that govern the determination of medical necessity. It would impose a payment adjustment as a mechanism to disqualify patients for hospital services and intrude upon physician's ability to admit patients to LTCHs based on the patient's need for specific programs of care and services provided by LTCHs.

Under the current SSO policy, a LTCH will at best receive only cost for a short-stay patient. There is certainly no incentive to admit a patient who is likely to be a short-stay outlier. Under the proposed extreme SSO policy, Edmond Specialty Hospital undoubtedly would lose a significant sum when treating Medicare patients who discharged early irregardless of the reason.

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 failures, and 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 prescreen patients and effectively identify which patients may become SSOs. There are a myriad of reasons why a patient admitted to a LTCH may become a short-stay outlier. Some SSO cased may achieve medical stability sooner than originally expected. Others may become SSO cases due to their unexpected death. In my opinion, patients who expire should never be counted as a SSO.

Physicians at acute care hospitals (ACH) 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 that 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.

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 in an ACH instead of being transferred to a LTCH, and thus delay the commencement of needed specialty services, purely for payment system reasons.

There is no basis for a proposed rule which assumes that SSO cases should have remained in acute care hospitals, and there simply is no support for CMS's belief or presumption that patients in LTCHs should be paid the same as patients in an acute care hospital.

Edmond Specialty Hospital respectfully requests that CMS not expand the 25% rule to freestanding long-term care hospitals, and that it reject the extreme short-stay outlier policy under consideration.

Sincerely,

George H. Dashner, FACHE
Chief Executive Officer

Form 59-1
letter

March 16, 2007

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

To Whom It May Concern:

Your proposed regulatory change, posted on January 25, 2007, could have very negative consequences on the ability of CareLink of Jackson (a long term acute care hospital) to provide essential healthcare services to Medicare patients in our community. These patients have many complex health problems that affect every minute of their lives. If put into action, the proposed rule would limit the number of patients an LTCH can admit from any one facility to only 25% of its admissions in order to receive full payment. Our community has only one acute care hospital. CMS had previously declared a 25% rule for "hospitals-within-hospitals," the proposed change would include free-standing hospitals.

This proposal will greatly limit access to the services that we and other LTCH's currently provide to patients who need longer hospital stays than ordinary patients. A lot of these long term patients are trying to get off of ventilators or are recovering from serious conditions that are damaging their lives. I understand that spending for this type of care is less than one percent of total Medicare spending, but having this level of care available in our community is priceless to these patients who are struggling with complicated medical conditions. If this change is put into effect it would have serious consequences to not only our hospital, CareLink of Jackson, but to every small LTCH in our situation. Patients would have to go further away from home to receive the care they need, and their families would have to travel about 80 miles a day to see their loved ones. This would be at least 2,000 miles for an average length of stay of 25 days. It hurts me to think of the unnecessary stress that this would place on our patients and their families, both emotionally and financially.

I understand that the financial impact on CareLink would mean a huge drop in our operating budget. It would also mean that the only hospital in our community would have to keep these long-stay patients in their facility longer. I know that they have a limited number of beds, so if they had to keep the long-stay patients it would limit the number of other patients they could accept. Think about the distress and potential delay in care it could cause if you or a loved one couldn't be admitted to the hospital because they didn't have any open beds. Passing this proposed rule would hit the Jackson community very hard.

I agree that clear and uniform admission criteria are needed to make sure that only the right types of patients are admitted to our level of care. I am very concerned though that the proposed rule, if put into effect, would have harmful and permanent consequences to the patients that we and other LTCH's serve. I am sure you will agree that it is very important that policy changes and reforms aren't abruptly imposed in such a way that it harms LTCH's and the patients who require our services. As a concerned citizen and CareLink staff member I wholeheartedly request you reconsider implementation of the proposed CMS Rules in 2008.

Sincerely,

Sandra Meyer, RRT, Mgr.

60

March 21, 2007

Leslie Norwalk

RE: Medicare Program, 2008 Proposed Update Rule; 72 Federal Register 4776 *et seq.*

Dear Ms.Nowalk :

As a Board Member of Bay Regional Medical Center, I am writing this letter to encourage you to request that CMS not expand the 25% rule, as it will negatively impact our community's long-term care hospital—Bay Special Care Hospital.

Bay Special Care Hospital was established on June 30, 1994 and is located in Bay City, Michigan. Since its inception, it has been the premier provider of long-term acute care hospital services within our geographic area. It provides direct patient care to approximately 300 patients annually, focusing on the complex medically compromised patients within our community – if the proposed changes to the current legislation are allowed to be implemented, this will seriously compromise those patients. Bay Regional Medical Center is the only acute-care hospital within the county and provides more than the proposed 25% cap of admissions from a single source facility. If this legislation is implemented, Bay Special Care Hospital will be unable to fulfill its mission of providing care to this patient population.

The proposed change in the rule would preclude patients from being provided optimum care within our own community and impose an undue hardship on the patients and their families. Approximately 48% of Bay Special Care Hospital's patients are discharged home—this is accomplished because of the excellent, quality care these individuals receive from this special facility.

If this rule change were allowed to move forward, in addition to impeding patient management, the potential economic impact on the employees and the community would be substantial. Employees potentially would lose their jobs, which would have an immediate impact within our local economy.

Again, I respectfully ask that you not support the current language in the rule, and request that the CMS not expand the 25% rule to freestanding and grandfathered hospitals and reject the extreme SSO policy currently under consideration.

Sincerely,

Mitzi Rowley Dimitroff

REVEREND ANDREAS TEICH
2275 CARROLL RD
BAY CITY MI 48708

March 21, 2007

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

RE: Medicare Program, 2008 Proposed Update Rule
72 Federal Register 4776 *et seq.*

Dear Ms. Norwalk,

For over three years, I have had the privilege of serving on the Board of Directors of Bay Special Care Hospital. As a pastor in this community, I had visited people at Bay Special Care Hospital and realized that they were receiving excellent care. I was delighted to be asked to serve in a position of oversight ensuring that all our patients would continue to receive such quality care in a fiscally responsible manner.

Bay Special Care Hospital was established on June 30, 1994 and is located at 3250 E. Midland Road, Bay City, Michigan 48706 and since its inception, has been the premier provider of long term acute care hospital services within our geographic area. Licensed for 31 beds, we provide direct patient care to approximately 300 patients annually, focusing on the complex medically compromised patients within our community – if the proposed changes to the current legislation are allowed to be implemented, this will seriously compromise these patients. In our geographic locality, there is only one acute care hospital, which does provide more than the proposed 25% cap of admissions from a single source facility, and if this legislation is implemented, we will be unable to fulfill our mission of providing care to this patient population.

The proposed change in the rule would preclude patients from being provided optimum care within their own community and impose an undue hardship on them and their families. Additionally, we are able to proudly state that approximately 48% of our patients are discharged home. This is quite a remarkable statistic, given the age and medical complexity of our patients.

If this rule change is allowed to move forward, in addition to impeding patient management, the potential economic impact on the employees and the community would be substantial. Employees potentially would lose their jobs which would have an immediate impact within the local economy.

I would respectfully ask that you not support the current language in the rule, and:

- Request that the CMS not expand the 25% rule to freestanding and grandfathered hospitals and reject the extreme SSO policy currently under consideration.
- I support the six-month extension for comments to allow the national trade organizations to collaborate for the good of the industry.
- I support a LTAC moratorium until 2010, as substantiated in the study of the Lewin Group.
- I support the development of a universal admission, continued stay and discharge criteria for LTACs, based on a validated study
- I support continued QIO review and oversight of the LTAC industry.

As a proud board member of a LTAC hospital, I respectfully request that you take these comments into consideration prior to the final ruling. Thank you.

Respectfully submitted,

Andreas Teich, Pastor

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COLUMBUS SPECIALTY HOSPITAL, INC.

Our Compassion Makes The Difference

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:

Columbus 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.

Columbus Specialty Hospital was established on May 3, 2003 and is located at 710 Center Street, 9th Floor, Columbus, Georgia 31901. It serves a significant percentage of Medicare patients residing in the West Central Georgia and East Central, Alabama. 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 Columbus Specialty Hospital in fiscal year 2008 by approximately 3% percent, forcing Columbus Specialty Hospital to operate at a loss when treating Medicare patients. Columbus Specialty 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 Columbus Specialty 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

P.O. Box 910 □ 710 Center Street □ 9th Floor □ Columbus, Georgia 31901 □ Telephone 706/321-6712

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.

Columbus Specialty 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.

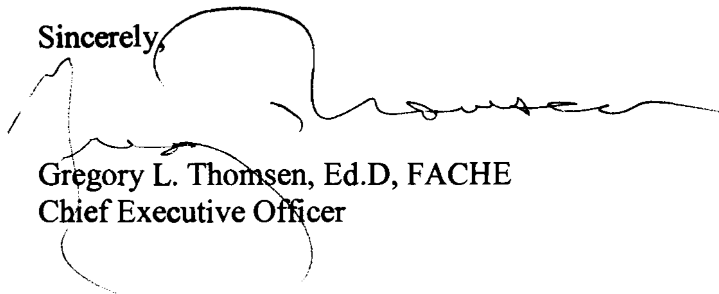
CMS also disregards the fact that a percentage of SSO cases are crossover cases that exhaust Medicare Part A benefits during their LTCH stay. It would be unfair to preclude these Medicare recipients from admission to an LTCH simply based on the number of their remaining Medicare days.

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 Columbus Specialty 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,



Gregory L. Thomsen, Ed.D, FACHE
Chief Executive Officer

THE
SPECIALTY
HOSPITAL
OF MERIDIAN

March 15, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1529-P
PO 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:

The Specialty Hospital of Meridian 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.

Specialty was established on September 1994 and is located at 1314 19th Avenue. It serves a significant percentage of Medicare patients residing in the East Mississippi and West Alabama. 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 The Specialty Hospital of Meridian in fiscal year 2008 by approximately nineteen (19) percent, forcing Specialty to operate at a loss when treating Medicare patients. We urge 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 Specialty 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

"Restoring Quality to Life"

1314 19th Avenue • Meridian, Mississippi 39301 • 601/486-4211 • Toll Free 1-888-THE-LTAC • Fax: 601/703-4294

than presumptions and beliefs. CMS' own contractor, RTI, noted in the Executive Summary to its report that "understanding 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.

The Specialty Hospital of Meridian 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.

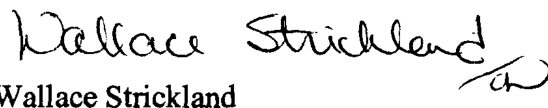
CMS also disregards the fact that a percentage of SSO cases are crossover cases that exhaust Medicare Part A benefits during their LTCH stay. It would be unfair to preclude these Medicare recipients from admission to an LTCH simply based on the number of their remaining Medicare days.

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 The Specialty 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,



Wallace Strickland

TEXOMA HEALTHCARE SYSTEM

March 13, 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:

TMC Restorative 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.

Restorative Care Hospital was established on 11/15/1993 and is located at 1000 Memorial Drive, Dension, Texas 75020. It serves a significant percentage of Medicare patients residing in the Texoma 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. The two proposals would drastically reduce payments to Restorative Care Hospital in fiscal year 2008 by approximately 50% percent, forcing Restorative Care Hospital to operate at a loss when treating Medicare patients. Restorative 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 Restorative 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.

Restorative 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.

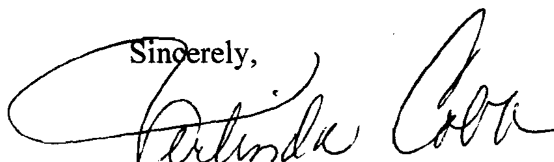
CMS also disregards the fact that a percentage of SSO cases are crossover cases that exhaust Medicare Part A benefits during their LTCH stay. It would be unfair to preclude these Medicare recipients from admission to an LTCH simply based on the number of their remaining Medicare days.

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 Restorative 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,



Verlinda Cobb

MAR 26 2007

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March 22, 2007

Hon. Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear Ms. Norwalk:

Recently, CMS released proposed regulation concerning "Long Term Acute Care" (LTAC) hospitals. The proposed rules represent a significant departure from the regulatory environment under which LTAC hospitals have recently operated. Over the last few years, LTAC hospitals have been burdened with payment volatility (i.e., hospital-within-hospital rule, short stay outlier payment changes, rate reductions) that makes strategic planning very challenging. We are concerned with the proposed rule on many fronts, and specifically, we ask that you reconsider any further expansion of the 25% rule to freestanding LTAC hospitals.

As you are aware, at the request of CMS the RTI study was commissioned to gain a better understanding of where in the health care continuum LTAC hospitals can provide the most value to Medicare. Within the data-filled report the distinction between acute hospital services and LTAC hospital services is still "poorly understood". The RTI Report laid a solid foundation for further work to be done and legislation has been introduced in both chambers of Congress to bring the attention needed to LTAC hospital admission criteria. These criteria are a very appropriate and responsible way of addressing concerns of making sure patients are treated in the most cost effective setting without compromising the most important factor – quality.

Medical decisions made by highly skilled and trained physicians should be the defining method by which patients are placed in certain post acute care facilities. LTAC hospitals are uniquely positioned to treat a group of medically complex patients who will require a lengthy hospitalization in which a team of professionals work in coordination to improve their outcome. It is this teamwork that makes LTAC hospitals unique and valuable to Medicare patients. Patient and facility level criteria that drive appropriate admissions, combined with physician decision making will do more for patients who benefit greatly from the post-acute care system than the proposed regulatory changes that will suffocate the LTAC continuum as we currently know it.

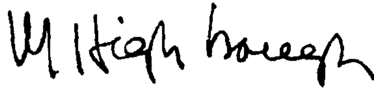
Congress, CMS and health care providers across the nation are working together on the challenging task of creating a framework that allows for the continual provision safe, quality and cost effective care to patients. The extension of the 25% rule would introduce massive

inefficiencies and disruption to the continuity of care. Because of an arbitrary number, a single physician maybe told one day his patient can be accepted, but the next day he or she will have to find an alternative place for their patients needs to be met. LTAC hospital cost structures will increase as they scramble to find patients from a variety of sources, not always in the best interest of patient care, but rather to meet this regulatory requirement.

Therefore, we strongly encourage you to reconsider the expansion of the 25 percent rule to freestanding LTAC hospitals. Furthermore, additional arbitrary payment cuts are putting at risk the ability for medically fragile patients to receive care in an LTAC setting the RTI report deems a viable and important part of the health care continuum. Let's work together in building a lasting framework that ensures the appropriate patients receive the appropriate care they deserve in the right setting and not limit supply based on arbitrary numbers.

Thank you for the opportunity to comment on the proposed rule.

Sincerely,



Scott Peek
President
Baylor Specialty Hospital

D. Michael Highbaugh, M.D.
Medical Director
Baylor Specialty Hospital

Jean DeLeon, M.D.
Assoc. Medical Director
Baylor Specialty Hospital

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MAR 26 2007

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.*

Improving the health status of the people of mid-Michigan by providing quality, compassionate, cost-effective health care.

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

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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.

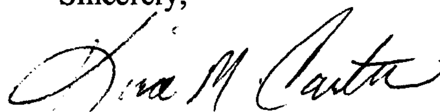
I understand the concern as expressed in the RTI study regarding growth and abuse in the LTCH industry. As a Michigan based LTCH provider, I can tell you that I have not seen this behavior. Michigan is a Certificate of Need State so the number of LTCH beds is determined and approved by the State, in 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:
<u>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</u>:

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

MAR 26 2007

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March 23, 2007

Centers for Medicare & Medicaid Services
Department of Health and Humans Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

REF: CMS-1529-P; Payment for Direct Graduate Medical Education

On behalf of Providence Health & Services, I want to thank you for the opportunity to provide our comments on the changes proposed by the Centers for Medicare & Medicaid Services regarding Payment for Direct Graduate Medical Education (GME) published in the *Federal Register* on February 1, 2007.

Providence Health & Services is a faith-based, non-profit health system that operates acute care hospitals, physician groups, skilled nursing facilities, home health agencies, assisted living, senior housing, PACE programs, and a health plan in Washington, Oregon, California and Montana. Providence Health & Services currently provides GME at many of our hospital and nonhospital sites throughout our health system.

As a Catholic health care system striving to meet the health needs of people as they journey through life, Providence Health & Services is pleased to submit the following comments on the above Proposed Rule, which was published in the *Federal Register* (Vol. 72, No. 21, pages 4818-4829) on February 1, 2007.

Providence Health & Services supports the efforts by CMS to provide some flexibility in the concept of paying for "all or substantially all" of the costs associated with training at nonhospital sites. We also support the efforts by CMS to reduce the burden of capturing those costs by use of proxies for the time spent and salaries of teaching physicians. However, Providence Health & Services advocates that the need to calculate the compensation of the teaching physician who is volunteering his or her time in the nonhospital setting is unnecessary. In the event that such calculation is required, Providence Health & Services advocates that any proxy of physician salaries account for geographic variations.

Volunteer Teaching Physicians

Providence Health & Services strongly believes that the training of residents in primary care offices and nonhospital settings is essential to the success of future family and internal medicine, as these are the sites where most family and internal medicine physicians will

eventually practice. Congress supports such efforts as evidenced by the provisions in the Balanced Budget Act of 1997 that encouraged physician training in ambulatory settings.

Many teaching physicians in nonhospital settings choose to volunteer both their time and supervisory efforts to train the physicians of tomorrow. However, under both the current and proposed payment methodology for GME, CMS refuses to recognize that teaching physicians can selflessly give of their time and effort to train residents without the nonhospital site incurring costs that must be reimbursed. A hospital must pay "all or substantially all" of the costs associated with the nonhospital training program in order to count residents participating in such programs as part of their computation of FTE residents for purposes of direct GME payments. CMS has proposed a formula to calculate "all or substantially all" of the costs based on variables such as teaching physician salary, residents' salaries and fringe benefits, the number of hours per week that the teaching physician spends in direct GME activities in the nonhospital site, and the number of hours that a nonhospital site is open each week. CMS's position is that a nonhospital site incurs costs associated with salaried teaching physicians supervising residents and a physician's desire to volunteer their time and supervisory effort does not erase these associated costs. Providence Health & Services disagrees with this position and maintains that physicians who choose to volunteer their time to supervise residents can do so without adding costs to the nonhospital site.

Recommendation:

Providence Health & Services urges CMS to recognize that teaching physicians may volunteer their time and supervisory efforts without adding costs to the nonhospital site. If a nonhospital site certifies that there are no supervisory costs because the physician is volunteering his or her time, then the hospital need not make any supervisory payments to the nonhospital site. With such certification, **CMS should remove the portion of the teaching physician's compensation attributable to direct GME activities from the calculation methodology.**

National Average Physician Salary Data by Specialty

CMS is proposing to allow hospitals to use national average physician salary information as a proxy for teaching physician-specific salaries in the determination of the total cost of the program at a non-hospital site. There are a number of organizations that conduct annual national surveys on physician compensation and CMS is considering using the data from the American Medical Group Association (AMGA). Although CMS clearly recognizes that there are geographic variations in salary amounts within each specialty, and that these variations are readily available from AMGA, the proposed calculation uses only a single national average or median salary amount for each specialty. CMS states the reasons for the decision to discount geographic variations are to simplify and streamline the proposed methodology for determining the GME costs in nonhospital sites as much as possible. *Federal Register*, Vol. 72, No. 21, pg. 4824, February 1, 2007.

These geographic variations are too substantial for CMS to ignore for the purpose of simplicity in the calculation of costs at nonhospital sites. One reason CMS allows the use of proxy information for physician salaries is the recognition that many physicians are reluctant to share their specific annual compensation amounts. By not factoring in geographic salary variations into the formula of cost calculation, CMS is placing hospitals in the predicament of either relying on national salary data that inaccurately represents physician salaries or

forcing hospitals to attempt to obtain actual physician compensation amounts for use in the cost equations.

> <u>Recommendation:</u>
> **In the event that the teaching physician's compensation is not removed from the calculation methodology, Providence Health & Services urges CMS to adopt physician salary data by specialty which accounts for geographic variations.**

In closing, Providence Health & Services would like to thank you for the opportunity to review and comment on the proposed rule regarding Payment for Direct Graduate Medical Education. Please contact Elizabeth Schultz, System Manager, Regulatory Affairs, at (206) 464-4738 or via e-mail at Elizabeth.Schultz@providence.org if you have questions about the material in this letter.

Sincerely,

John Koster, M.D.
President/Chief Executive Officer
Providence Health & Services

March 23, 2007

Centers for Medicare & Medicaid Services
Department of Health and Humans Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
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Many teaching physicians in nonhospital settings choose to volunteer both their time and supervisory efforts to train the physicians of tomorrow. However, under both the current and proposed payment methodology for GME, CMS refuses to recognize that teaching physicians can selflessly give of their time and effort to train residents without the nonhospital site incurring costs that must be reimbursed. A hospital must pay "all or substantially all" of the costs associated with the nonhospital training program in order to count residents participating in such programs as part of their computation of FTE residents for purposes of direct GME payments. CMS has proposed a formula to calculate "all or substantially all" of the costs based on variables such as teaching physician salary, residents' salaries and fringe benefits, the number of hours per week that the teaching physician spends in direct GME activities in the nonhospital site, and the number of hours that a nonhospital site is open each week. CMS's position is that a nonhospital site incurs costs associated with salaried teaching physicians supervising residents and a physician's desire to volunteer their time and supervisory effort does not erase these associated costs. Providence Health & Services disagrees with this position and maintains that physicians who choose to volunteer their time to supervise residents can do so without adding costs to the nonhospital site.

Recommendation:

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John Koster, M.D.
President/Chief Executive Officer
Providence Health & Services

March 23, 2007

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Providence Health & Services urges CMS to recognize that teaching physicians may volunteer their time and supervisory efforts without adding costs to the nonhospital site. If a nonhospital site certifies that there are no supervisory costs because the physician is volunteering his or her time, then the hospital need not make any supervisory payments to the nonhospital site. With such certification, **CMS should remove the portion of the teaching physician's compensation attributable to direct GME activities from the calculation methodology.**

National Average Physician Salary Data by Specialty

CMS is proposing to allow hospitals to use national average physician salary information as a proxy for teaching physician-specific salaries in the determination of the total cost of the program at a non-hospital site. There are a number of organizations that conduct annual national surveys on physician compensation and CMS is considering using the data from the American Medical Group Association (AMGA). Although CMS clearly recognizes that there are geographic variations in salary amounts within each specialty, and that these variations are readily available from AMGA, the proposed calculation uses only a single national average or median salary amount for each specialty. CMS states the reasons for the decision to discount geographic variations are to simplify and streamline the proposed methodology for determining the GME costs in nonhospital sites as much as possible. *Federal Register*, Vol. 72, No. 21, pg. 4824, February 1, 2007.

These geographic variations are too substantial for CMS to ignore for the purpose of simplicity in the calculation of costs at nonhospital sites. One reason CMS allows the use of proxy information for physician salaries is the recognition that many physicians are reluctant to share their specific annual compensation amounts. By not factoring in geographic salary variations into the formula of cost calculation, CMS is placing hospitals in the predicament of either relying on national salary data that inaccurately represents physician salaries or

forcing hospitals to attempt to obtain actual physician compensation amounts for use in the cost equations.

Recommendation:

In the event that the teaching physician's compensation is not removed from the calculation methodology, Providence Health & Services urges CMS to adopt physician salary data by specialty which accounts for geographic variations.

In closing, Providence Health & Services would like to thank you for the opportunity to review and comment on the proposed rule regarding Payment for Direct Graduate Medical Education. Please contact Elizabeth Schultz, System Manager, Regulatory Affairs, at (206) 464-4738 or via e-mail at Elizabeth.Schultz@providence.org if you have questions about the material in this letter.

Sincerely,

John Koster, M.D.
President/Chief Executive Officer
Providence Health & Services

American Hospital
Association

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March 26, 2007

MAR 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

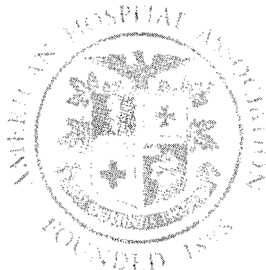
RE: (CMS–1529–P) Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes, (Vol. 72, No. 21), February 1, 2007

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

69

Massachusetts Hospital
Association

MAR 26 2007

March 23, 2007

Leslie Norwalk
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; 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 Massachusetts Hospital Association (MHA), on behalf of our member hospitals and health systems, submits this letter to comment on the 2008 proposed Long-Term Care Hospital Prospective Payment System. Massachusetts is home to many of the nation's oldest long-term care hospitals (LTCH) that provide some of the most clinically complex post-acute hospital care. We are very concerned with the significant changes being proposed in this rule and the impact it will have on the ability of our state's long-term hospitals to adequately care for vulnerable patient populations. Of significant concern are the proposals to: (1) expand the 25% Rule to all Long Term Care Hospitals (LTCHs), including free-standing, satellite, and grandfathered hospital-within-hospitals; (2) expanding the Short Stay Outlier policy by adding a new payment alternative; 3) reduce the annual update to LTCH PPS by 2.49%; and (4) expand the outlier threshold prior to applying the budget neutrality for the LTCH DRG weights. The overall net effect of these and other proposals are to reduce overall LTCH Medicare payments by 2.9 percent in Rate Year 2008. We believe viable alternatives are available for CMS to consider that will provide the needed cost savings to the Medicare program, while assuring that the clinical determination of appropriate level of care continue to be based on medical necessity determination. We recommend several of these viable alternatives to you.

Proposed Changes to LTCH PPS Payment Rates for the 2008 LTCH Rate Year

1) Proposed Expansion of the so called 25% rule to all Long Term Care Hospitals (LTCHs), including free-standing, satellite, and grandfathered hospital-within-hospitals.

CMS' intent of expanding the 25% rule is apparently based solely on its desire to limit early discharge of patients from acute care hospitals to long term care hospitals, and, by so doing, to reduce overall Medicare expenditures. What is missing from the proposed rule is any discussion about proposals for implementing patient and facility standards of care to ensure

access to cost-effective and appropriate care. Patients in long-term care hospitals are severely ill and require specialized care that may not be available in other settings. Yet instead of focusing on the medical needs of patients in determining whether treatment in a long-term care hospital is appropriate, the rule implements arbitrary payment reductions to regulate patient access to needed medical care.

As quoted throughout the preamble, CMS is apparently acting on MedPAC recommendations about ensuring consistency of the payment policies from LTCH satellites to freestanding and other LTCH facilities. However, there is no mention about the other MedPAC recommendations that CMS should also develop and implement uniform patient and facility admissions criteria to ensure appropriate placement of medical complex patients in appropriate post-acute settings. While there are plans to develop a uniform patient assessment tool for all post-acute care settings, there is no discussion about appropriate admission criteria as well.

While the stated goal of the proposed policy is to reduce overall Medicare expenditures by reducing the increased growth of co-located LTCHs, the end result will be to reduce patient access to needed medical services. This provision in the proposed rule only serves to override physician decision-making as to the appropriate placement of patients for medically necessary care. The 25% rule effectively makes the acute hospital outlier payment policy a substitute for medical determination of the necessity of LTCH programs of care

MHA recommends that CMS not adopt any expansion of the so called 25% rule. Instead CMS should establish patient admission criteria, or develop the uniform patient assessment tool for post-acute care placement. If the concern is about inappropriate discharge practices to co-located providers, then MHA further recommends that CMS implement a moratorium on certification of new LTCHs until uniform patient assessment and admission criteria are established to ensure appropriate placement in an LTCH or alternate site of care. Finally, MHA agrees with CMS and recommends that it maintain the language in the preamble that clarifies that the application of any referral arrangement under the 25% rule is based on the referral from a hospital campus as defined by CMS provider based regulations.

2) Expansion of the short stay outlier policy by the addition of a new payment alternative:

CMS is considering the addition of another short stay threshold for the shortest stay SSO cases (those with a LOS less than or equal to the mean LOS plus one standard deviation for that DRG under IPPS). In such cases, CMS is considering altering the fourth alternative under the SSO payment methodology to be 100% of the IPPS per diem (as opposed to the current blend). Under this approach, SSO cases with covered lengths of stay that exceed the comparable IPPS threshold, but are still below the old threshold of five-sixths of the LTC mean, would continue to be paid under the existing policy.

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.**

3) 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. 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.

MHA Recommends that 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.

4) Proposed Adjustment for the High Cost Outlier Threshold:

Although the determination of the high cost outlier threshold is based on the LTCH PPS payment for the LTCH-DRG plus a fixed loss amount, it is not reasonable to make any changes to the outlier threshold if CMS is also planning to change the LTCH-DRG weights to be budget neutral in October of this year.

MHA Recommends that given the fact that the calculation of the High Cost Outliers are based on the LTCH –DRG weights, any new calculation should be made once the weights are updated in a budget neutral manner. Therefore, we recommend that CMS delay any changes to the LTCH High Cost Outlier Threshold until October of 2007 and incorporate it as part of the Inpatient PPS rule to ensure that any calculation reflects the true DRG-weights. If changes are made effective July 1, 2007, then CMS will have to make further changes to the threshold based on the new weights starting on October 1, 2007 as well.

MHA strongly believes that there should be no major policy changes until CMS has reviewed and addressed the inconsistencies and issues outlined in our letter. CMS also should consider

the proposals that we have outlined above to ensure that our severely ill and medically complex Medicare patients have access to specialized services and programs of care that may not otherwise be available in other alternative settings.

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.

MHA 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.

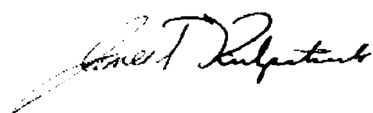
We suggest that CMS consider using reasonable cost equivalents (RCE), which are calculated from CMS' data, available to the public and are a stable source of salary proxies. If CMS decides against using RCEs, we would recommend using the Association of American Medical Colleges' (AAMC's) Faculty Roster 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.

MHA 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 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

MAR 22 2007

March 21, 2007

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ATTN.: CMS-1529-P

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, Federal Register, Volume 72, No. 21, Thursday, February 1, 2007

Dear Ms. Norwalk:

On behalf of our approximately 200 member hospitals and health care systems, the Illinois Hospital Association (IHA) is taking this opportunity to formally comment on the proposed rule establishing new policies and payment rates for long-term care hospital inpatient services for fiscal year 2008, as well as a proposed change in the determination of Medicare graduate education payments. IHA commends the Centers for Medicare and Medicaid Services (CMS) for its thorough analysis in the development of this rule; however, the Association does have some concerns with several of the provisions. Therefore, in accordance with instructions in the rule, the Illinois Hospital Association presents the following comments for your consideration:

1. LTC-DRG CLASSIFICATIONS AND RELATIVE WEIGHTS:

The Centers for Medicare and Medicaid Services (CMS) is presently reviewing its current methodology for establish Diagnostic Related Groups (DRGs) in the acute hospital inpatient system. Specifically, it is establishing a severity component that could add as many as 300 more DRGs to the current listing. There is no reference in the LTCH proposed rule as to the impact of this review on the LTC-DRG classifications. The Illinois Hospital Association is concerned about the impact of this review on the LTC-DRG system. Does CMS intend to replicate any changes to the inpatient acute classification system as part of the long-term care classification system? If so, when would these changes become public, so that the long-term care industry representatives would have sufficient time to review them and submit comments?

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

- The Illinois Hospital Association, while applauding CMS' intent to update the annual base rate by the full market basket, is concerned that the effective rate of increase is only 0.71% after application of a "coding improvement" factor. The percentage reduction applied as a

result of this approach (2.49%) virtually eliminates the entire scheduled market basket increase. While not disagreeing with this adjustment in principle, the IHA suggests that CMS consider a "phase-in" of such adjustments, possibly 50% (1.25%) in FY 2008 and (1.24%) in FY 2009. As the impact of coding improvements is expected to diminish over time, a transition of this percentage reduction (especially a reduction that is almost equal to the full update percentage) would help those long term care hospitals continue to serve their Medicare patients in a more efficient manner.

3. OTHER PROPOSED POLICY CHANGES FOR THE 2008 LTCH PPS RATE YEAR:

- CMS has proposed a 26 % increase in the fixed outlier threshold for FY 2008. This is a substantial increase to implement in one year and the Illinois Hospital Association would recommend reducing this increase in the final rule.

4. PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION:

- While the Illinois Hospital Association commends CMS for specifically clarifying the "all or substantially all of the costs for the training program in the non-hospital setting," it is concerned that the proposed date of implementation of the "90% rule" (cost reporting periods beginning on or after July 1, 2007) does not give sufficient time for hospitals to adequately prepare their documentation. Budgets for academic years that begin in September are typically finalized earlier in that year. In order to not place undue reporting burdens or changes in documentation processes on these hospitals, IHA recommends that CMS change the effective date in its final rule to cost reporting periods beginning on or after July 1, 2008.

Ms. Norwalk, thank you again for the opportunity to comment. The Illinois Hospital Association welcomes the opportunity to work with your agency in the continued development and refinement of the Medicare payment system.

Sincerely,

Thomas A. Jendro
Senior Director-Finance
Illinois Hospital Association
(630) 276-5516
tjendro@ihastaff.org