Charles N. Kahn III
President

June 29, 2009

Hon. Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1406-P, CMS-1337-IFC, and CMS-1406-P2
P.O. Box 8011
Baltimore, Maryland 21244-1850

Re: Proposed Rule with Comment Period; Medicare Program; Proposed Changes to the Long-Term Care Hospital Prospective Payment Systems and Rate Year 2010 Rates; CMS-1406-P; 74 Federal Register 24080 (May 22, 2009);

Interim Final Rule with Comment Period; Medicare Program; Revisions to FY 2009 Medicare Severity-Long-Term Care Diagnosis-Related Group (MS–LTC–DRG) Weights; CMS-1337-IFC; 74 Fed. Reg. 26546 (June 3, 2009); and

Supplemental Proposed Rule; Medicare Program; Proposed Rate Year (RY) 2010 Medicare Severity-Long-Term Care Diagnosis-Related Group (MS–LTC–DRG) Relative Weights and High-Cost Outlier Fixed-Loss Amount; CMS-1406-P2; 74 Fed. Reg. 26601 (June 3, 2009)

Dear Ms. Frizzera:

The Federation of American Hospitals ("FAH") 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 hospitals in urban and rural America, including inpatient rehabilitation, long-term acute care, cancer and psychiatric hospitals. We appreciate the opportunity to provide these comments to the Centers for Medicare and Medicaid Services ("CMS") regarding the above referenced proposed and interim final rules ("Proposed Rule" or "Interim Rule" or "NPRM") regarding changes to the long-term acute care hospital ("LTACH") inpatient prospective payment system for rate year ("RY") 2010 and fiscal year (FY) 2009. Our comments

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with regard to the proposed and interim final rules to LTACH DRGs, which span three separate notices, appear in this comment letter as major section headings (e.g., I, II) that refer to each of the notices.

I. PROPOSED RULE FOR RY 2010, CMS 1406-P

- **Market Basket Update – Coding and Documentation Adjustment**

CMS proposed an increase in the standard federal rate based on a market basket update of 2.4 percent less an adjustment of 1.8 percent to account for perceived changes in documentation and coding practices. CMS relied on a case-mix index (CMI) analysis of LTACH claims data under both the current MS-LTC-DRGs and former CMS LTC-DRG patient classification systems to support this reduction to the market basket increase. Based on this evaluation, CMS determined that there was a total increase in LTACH CMI of 1.8 percent due to changes in documentation and coding that did not reflect real changes in patient severity of illness for LTACH discharges occurring in FY 2007 and FY 2008 (0.5 percent in FY 2007 and 1.3 percent in FY 2008).

For many of the same reasons set forth in the FAH's separate comment letter regarding the FY2010 inpatient acute care PPS ("IPPS") proposed rule with respect to a similar adjustment proposed for acute care hospital IPPS for FY 2010, the methodology and analysis CMS used to estimate the 1.8 percent downward adjustment to the standard federal rate is flawed and should not be used. CMS should increase the standard federal rate by the full market basket update of 2.4 percent for the following reasons.

Unlike the coding and documentation adjustment authorized by Congress and the Secretary for IPPS, neither the Medicare statute nor the Code of Federal Regulations authorizes CMS to adjust the market basket or the standard federal rate to account for changes in case-mix attributable to "apparent" case-mix. This seems clear from the applicable regulations.

For IPPS, see generally 42 C.F.R. sec. 412.64(c)-(e), the standardized amount is to be computed for all hospitals in all areas and is "increased" as specified in subsection (d). Subsection (d) includes the market basket percentage increase, and a negative adjustment if a hospital fails to submit quality data. This calculation results in an updated standardized amount. That update is subject to adjustments for budget neutrality under subsection (e), which specifically includes coding and documentation changes resulting from DRG classification changes, among other items. For LTACH PPS under 42 C.F.R. sec. 412.523, the federal rate calculation includes a market basket adjustment each period. That rate is adjusted under subsection (d) for outlier payments and budget neutrality, with no mention in the budget neutrality adjustment for case-mix, coding or documentation changes, unlike IPPS. Therefore, it seems clear that CMS would have no authority to introduce those concepts into the market basket update, which is intended to reflect the 2.4 percent increase in prices LTACHs will face.

Even if CMS were considered to have this authority, the proposed rule does not account for prior reductions to annual updates to LTACH PPS that address documentation and coding practices. These reductions totaled 6.59 percent from FY07 through FY09 to account for case-mix change in FY04 – FY06, respectively. As a result of these relentless reductions at the same time the prices of goods and services LTACHs need to deliver intensive care has experienced a sustained increase, LTACH payment adequacy has been severely undermined.

CMS supplies inadequate data to support making the adjustment and proposes an update to the standard federal rate on data that is neither verifiable nor necessarily relevant. CMS calculated the update factor by subtracting from the estimated increase in the market basket (2.4 percent) the difference between "observed" increase in the case-mix (1.8 percent) minus what CMS deems the "real" case-mix increase (0.6 percent). 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, however, CMS relies on the estimate of real case-mix increase based on a RAND study of IPPS hospitals published in 1991 and conducted on claims data from 1987 to 1988. Yet, the Agency does not adequately explain how these data can be imputed to a different provider type twenty years later. CMS would need to undertake a similarly exhaustive study of case-mix in LTACHs to understand and explain what the "real" case-mix changes have historically been.

For all the reasons set forth above, the FAH believes a full market basket update of 2.4 percent is warranted and recommends that CMS update LTCAH payments accordingly.

- **LTACH Stand-Alone Market Basket**

CMS states in the proposed rule that the agency is exploring the possibility of implementing three separate, stand-alone market baskets for hospitals excluded from the IPPS, rather than use an aggregate rehabilitation, psychiatric, long-term care (RPL) market basket, and requests comments on whether to create one for LTACHs. When the LTACH PPS was established, CMS said there were too few LTACHs to generate data to develop a market basket specific to their patient populations. However, the number of LTACHs has increased since 2002, so CMS now believes that it may be possible to create a market basket based solely on LTACH data.

The FAH agrees that there are sufficient LTACHs now to support a separate LTACH market basket. In order for the LTACH PPS to accurately reflect the costs of providing services in an LTACH, CMS should adopt a market basket that is limited to LTACH goods and services.

- **Satellite Facilities**

CMS suggests changes that would cause satellite facilities and hospitals-within-hospitals to operate under the same "separateness criteria." The proposed rule would amend the criteria for satellite facilities by adding language to prohibit the governing

body of the host hospital within which a satellite facility operates from being under the control of any third entity that also controls the satellite facility. However, the proposed rule would grandfather satellite facilities that are excluded from the IPPS during its cost reporting period beginning prior to October 1, 2009. Satellite facilities established after that period will be subject to this new prohibition.

CMS previously considered this issue when it established the "separateness criteria" and chose to adopt language that adequately addressed the concern that satellites remain sufficiently distinct from their host hospital. This change adds an additional layer of complexity to an already overly complex regulatory scheme. CMS offers no evidence that the proposed change will have any impact on the Medicare program or how services are provided to Medicare beneficiaries. Instead, CMS creates a new restriction on LTACHs accompanied by a new type of "grandfathering" that distinguishes yet another sub-category of LTACHs. CMS should withdraw this proposed change until there is compelling evidence that a new restriction of this type is necessary.

- **National Facility and Patient Criteria**

Congress directed the Secretary to conduct a study to determine medical necessity, appropriateness of admission and continued stay at LTACHs. A report on the study findings is due in June 2009.

As the FAH has previously commented, CMS should align its regulatory philosophy for LTACH's with that 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, an approach we strongly support. The CMS policies to date (e.g. the "25 percent rule") do not differentiate between patients based upon their condition or medical needs. Unfortunately, payment adjustments based on the percentage of Medicare patients admitted from a single facility advanced by CMS in recent rulemakings continues to rely on arbitrary and unproven payment reductions that do not achieve the stated policy goals and significantly hinders the ability of many LTACHs to provide quality patient care to Medicare beneficiaries. The development of comprehensive LTACH certification criteria is the correct approach if quality of care is to be encouraged.

Along those lines, the FAH is collaborating with the American Hospital Association, the Acute Long Term Care Hospital Association, and the National Association of Long Term Care Hospitals on a robust, comprehensive study to determine the feasibility of facility and patient criteria. The members of this working group believe this effort will help inform how LTACHs can efficiently administer medically complex care to severely ill patients. We look forward to working with CMS and other stakeholders to develop new LTACH facility and patient criteria that are supported by the ongoing research in this area.

II. INTERIM FINAL RULE FOR FY 2009, CMS-1337-IFC

This interim final rule with comment period implements revised MS-LTC-DRG relative weights for payment under the LTACH PPS for the remainder of FY 2009 due to CMS's misapplication of its own methodology in the calculation of the budget neutrality factor. CMS states that the calculation of the budget neutrality factor of 1.04186 was determined using the unadjusted recalibrated relative weights rather than using the normalized relative weights. The revised FY 2009 budget neutrality factor is 1.0030401. This error resulted in relative weights that are approximately 3.9 percent higher for all of FY 2009. CMS estimates a decrease in aggregate LTACH PPS payments of approximately $43 million (or approximately 0.9 percent) for all LTACHs through the end of FY 2009. CMS developed and proposed the relative weights over a period of months in the spring of 2008 and continued their use through 11 of the 15 months in FY 2009. CMS now has implemented an apparent correction during the current year without notice and comment rulemaking through an interim final rule with comment.

CMS estimates that, as a result of its error calculating the relative weights, aggregate annualized LTACH PPS payments in FY 2009 are $130 million greater than what the increase would have been had the FY 2009 budget neutrality factor been calculated consistent with the methodology CMS intended to follow. At the same time, CMS asserts in the preamble to the rule that "additional comment would be unnecessary." By CMS's own calculation the interim final rule will have a significant negative financial impact on LTACHs. This comes at a time of heightened financial stress for hospitals, and as MedPAC estimates LTCAH Medicare margins have fallen sharply, with a 2009 estimate that is virtually zero, at .5 percent, before the additional reductions CMS announced in these additional rulemakings. For this reason alone, LTACHs should be given the required period of time to review the proposal and assess the accuracy of CMS's revised calculations.

In the preamble to the rule, CMS states "it is unnecessary to undertake prior notice and comment rulemaking or provide a delay in effective date because this interim final rule with comment period simply reflects the appropriate application of the established methodology set forth in the FY 2009 IPPS final rule." However, without a sufficient opportunity to review the newly applied methodology, there is an insufficient opportunity to determine whether CMS's most recent attempt to calculate the budget neutrality factor is correct.

Under these circumstances, there is no compelling reason for deviating from the standard 60-day comment period. CMS should withdraw the interim final rule or at least convert the rule to a proposed rule with applicable notice and comment before it is effective.

III. SUPPLEMENTAL PROPOSED RULE FOR RY 2010, CMS-1406-P2

The supplemental proposed rule revises both proposed RY 2010 MS-LTC-DRG relative weights and the proposed RY 2010 high cost outlier (HCO) fixed-loss amount based on the revised FY 2009 MS-LTC-DRG relative weights presented in the interim final rule with comment period discussed above.

CMS presents a new Table 11(Amended) with revised RY 2010 MS-LTC-DRG relative weights based upon the application of the proposed RY 2010 normalization factor of 1.07264 and the proposed RY 2010 budget neutrality factor 0.993343. CMS estimates an increase in overall estimated payments in RY 2010 from FY 2009 of approximately $101 million (or about 2.2 percent). This is 0.6 percent lower than the 2.8 overall increase stated in the RY 2010 proposed rule.

CMS initially proposed to establish the fixed loss amount at $16,059, subject to any adjustment in the final rule. CMS proposed to decrease the fixed loss amount of $22,960 applied in RY 2009 for two reasons. First, CMS is projecting that the total outlier payments in RY 2009 will be approximately 6.1 percent of total LTACH PPS payments: 1.9 percentage points lower than the target rate of 8 percent. Second, based on current data, CMS also projects an increase in aggregate LTACH PPS payments in RY 2010 as compared to RY 2009. Therefore, CMS initially proposed to decrease the LTACH outlier threshold in RY 2010 to $16,059. In the supplemental proposed rule, CMS proposed a new fixed-loss amount of $18,868 for RY 2010.

The revised fixed-loss amount of $18,868 that CMS proposed in the supplemental proposed rule less than 30 days ago is a significant change that will have a material impact on LTACH payments for high cost outlier cases. The supplemental proposed rule does not comply with the requirements of notice and comment rulemaking, as discussed in greater detail above. CMS should give the public at least 60 days, as required under the Administrative Procedure Act and the Social Security Act, to conduct a meaningful study of the change and provide the agency with substantive comments on the proposal. There is sufficient time before the October 1 start date to RY 2010 for CMS to give the public the standard statutory period to submit meaningful comments and for the agency to consider those comments with respect to its regulatory proposals.

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The FAH appreciates the opportunity to comment on these rules. We would welcome an opportunity to meet, at your convenience, to discuss our views. If you have any questions, please feel free to contact me or Steve Speil, Senior Vice President, Health Finance and Policy, of my staff at (202) 624-1529.

Sincerely,