



ALTHA, INC.  
625 SLATERS LANE  
SUITE 302  
ALEXANDRIA, VA 22314

PHONE: 703.518.9900  
FAX: 703.518.9980  
WEBSITE: ALTHA.ORG  
INFO@ALTHA.ORG

March 20, 2008

The Honorable Kerry Weems  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
**Attention: CMS-1593-P**  
P.O. Box 8011  
Baltimore, MD 21244-1850

Re: 42 CFR Parts 412  
Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY  
2009: Proposed Annual Payment Rate Updates, Policy Changes, and Clarifications

Dear Mr. Weems,

This letter presents the Acute Long Term Hospital Association's (ALTHA) comments and recommendations on 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) 2009, which the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* on January 29, 2008. 73 Fed. Reg. 5342.

As we discuss more fully below, ALTHA commends CMS for its decision to consolidate LTACH rulemaking into one regulatory cycle, and we encourage CMS to consider publishing the LTACH rule separately from the inpatient prospective payment system (IPPS) rule. We also discuss our view of the agency's proposal to adjust the update to the standard federal rate by deducting 0.9 percentage points from the market basket increase for unsubstantiated "apparent" changes in coding behavior. In addition, we disagree with CMS' interpretation of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), which led to the application of the payment update to the RY 2007 standard federal rate rather than the RY 2008 standard federal rate. We also provide comments stating that CMS has not adequately incorporated the effects of the very-short stay outlier (VSSO) and other policy changes in the MMSEA on the calculation of a new fixed-loss amount for rate year RY 2009.

In this letter, we discuss our response to CMS' proposed methodology for calculating a one-time budget-neutrality adjustment (BNA) to account for calculation errors made in the shift from the old cost-based system to the current LTACH PPS. While the MMSEA prohibits the agency from making this adjustment for a three-year period, the agency has suggested its intent to implement this policy at the end of this period, which ALTHA opposes. This letter describes ALTHA's view that no adjustment is necessary now or in the future.

Finally, in this letter ALTHA responds to CMS' description of the work of the Research Triangle Institute (RTI) Technical Expert Panels (TEPs). ALTHA believes more LTACH experts should have been on the panel and we are concerned that CMS will use some panel members' uncertainty about the unique qualities of LTACHs as a reason for not implementing LTACH certification criteria. These criteria were called for by the Medicare Payment Advisory Commission (MedPAC) in 2004 and the MMSEA.

ALTHA represents the nation's leading LTACHs and works to protect access for medically complex patients to LTACHs by educating federal and state regulators, members of Congress, and other stakeholders about the role of LTACHs. ALTHA represents more than 300 LTACHs across the United States, constituting more than two-thirds of this provider community. Some of 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 and trust that CMS will carefully consider each of the issues raised in this letter.

#### **(1) ALTHA supports CMS' proposal to move to a single rulemaking cycle**

**Issue.** In the proposed regulation, CMS recommends to consolidate the annual updates for payment and Medicare severity-adjusted long-term care diagnosis related group (MS-LTC-DRG) relative weights into one annual update. CMS originally intended the twice-yearly system to reduce the burden on the agency in circulating concurrent publications of the annual updates for two payment systems (inpatient and LTACH). However, there is some duplicative resource use in producing separate regulations. Furthermore, CMS states it has received feedback that LTACHs face increased costs and operating complexities in accommodating two billing system updates per year. In order to transition this move to a single regulatory cycle, CMS proposes to extend RY 2009 by three months. This would mean that beginning fiscal year (FY) 2010 the LTACH rate year will begin October 1, coinciding with the start of the federal fiscal year.

**Comment.** ALTHA supports the CMS proposal to move to a single rulemaking cycle. This change will streamline billing updates, a point of concern for many of our member companies. ALTHA also feels that this simplification will be beneficial in allowing LTACHs to better assess the combined impact of the changes made for both payment updates and MS-LTC-DRG changes and relative weights. For example, in the last IPPS regulation CMS moved to a new severity-based patient classification system. While CMS proposed this change in April, the agency did not finalize additional payment and policy changes for the LTACH PPS until May. Furthermore, the comment period for the LTACH PPS rule had passed before CMS released the IPPS proposed regulation. This posed a difficulty for LTACHs in commenting on the proposed IPPS regulations. In contrast, IPPS hospitals had both their payment rates and MS-DRG system proposed at the same time, which provided ease of assessing the total impact of the regulation.

ALTHA believes that CMS' approach to implementing this provision by extending RY 2009 is reasonable. It is certain that the alternative approach of a 3-month rate year followed by a 12-month rate year would cause an administrative and operational burden. A 15-month rate year will allow stability in LTACH payment rates while creating an appropriate transition period. Furthermore, ALTHA is supportive of having the LTACH rate year coincide with the start of the federal fiscal year in line with IPPS hospitals and other post-acute care (PAC) providers.

ALTHA observes that CMS does not explicitly describe in the proposed rule how the agency will approach this combined rulemaking. Specifically, CMS does not state whether it will continue to publish the LTACH proposed and final regulations separate from the IPPS regulations, or if it will publish LTACH provisions within the IPPS regulation. This issue merits attention, and ALTHA urges CMS to describe the agency's plans and justification for either approach in the final rule.

**Recommendation.** ALTHA recommends that CMS move to a single rulemaking cycle and that the agency publish a separate LTACH PPS regulation apart from the IPPS regulation. ALTHA supports the proposal to make RY 2009 last 15 months. ALTHA recommends that in publishing this regulation CMS move the MS-LTC-DRG relative weight updates to the LTACH PPS regulation. ALTHA acknowledges that this may require CMS to repeat some of the information contained in the IPPS rule as it pertains to new, combined, or eliminated MS-DRGs (and subsequently MS-LTC-DRGs). Despite this duplication of information, ALTHA believes that the value of separate regulations is justified. A separate regulation will allow CMS and LTACH providers a clearer view of the policy changes that affect LTACHs, and will allow more accurate assessments of the impact of all changes on LTACH provider payments.

## **(2) CMS should update payments by the full market basket amount to LTACH providers in RY 2009**

**Issue.** CMS proposes that for RY 2009, LTACHs receive a 2.6 percent increase to the standard federal rate, which would set the standard federal rate at \$39,076.28. However, for that same period, CMS estimates that the market basket increase will be 3.5 percent. The difference between the proposed update of 2.6 percent and actual price increase of 3.5 percent is CMS' calculation of changes in case-mix not due to patient severity. CMS contends that changes in the case-mix index result from a combination of "real" changes and "apparent" changes. CMS defines the real case-mix index growth as the rise in the average MS-LTC-DRG relative weights resulting from the hospital's treatment of more resource intensive patients. CMS defines apparent case-mix as increases due entirely to changes in coding practices. After a downward adjustment to account for the increase in case-mix in the past two years (3.4 percent in RY 2007 and 0.9 percent in RY 2008), CMS proposes to reduce the market basket update for a third year in a row.

### **Comment.**

#### **A. ALTHA does not support the CMS proposal to reduce the market basket update on the grounds that CMS would not increase payments at a rate that matches inflation**

ALTHA strongly disagrees with CMS' decision to deduct this apparent case-mix from the market basket increase. The market basket increase is designed to address increases in the price of goods and services required by LTACHs to deliver care to Medicare beneficiaries. Indeed, the market basket update is the only mechanism in the prospective payment system that accounts for price inflation LTACHs face in delivering care for every patient treated. The cost inputs CMS lays out in the Rehabilitation, Psychiatric, and Long-Term Care (RPL) market basket do not include a case-mix element. Changes in case-mix dominate the method used by CMS to update payments

to LTACHs, even though case-mix has little to do with price inputs that comprise the market basket. In the regulation, CMS acknowledges that prices will increase by 3.5 percent over the next rate year, and yet contradictory to the intention of the market basket update mechanism, denies LTACHs full reimbursement for those price changes. ALTHA is fundamentally opposed to the notion that it is acceptable to not reimburse providers fully for price inflation. Payment adequacy is extremely important to maintaining access by Medicare beneficiaries to LTACHs and ensuring high-quality care.

ALTHA remains concerned about the appropriateness of a downward adjustment to the market basket for case-mix changes. Nowhere in the regulations 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 42 C.F.R. § 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 BNA. Case-mix changes are not included. Therefore, CMS should not introduce the foreign notion of a case-mix adjustment to the market basket update, which is intended to reflect the 3.5 percent rise in prices LTACHs face next year.

In addition, ALTHA believes that the proposal to make an adjustment for past payments to future payments violates the philosophy of a prospective payment system. In many instances, including when CMS does not accurately predict the real market basket change in prices, CMS states that it will not make a correction for the error in future years because that violates the nature of a prospective payment system. It is therefore troubling to ALTHA that CMS would violate this principal in this case.

ALTHA also believes that this proposal is in direct conflict with CMS' most recent statements on apparent case-mix changes. In the FY 2008 inpatient PPS regulation, CMS states that so-called apparent case-mix is no longer a concern to the agency. This is the rationale CMS gives for finalizing the policy of updating the MS-LTC-DRG relative weights in a budget-neutral manner. Based on this policy, CMS should not make an apparent case-mix adjustment to the LTACH market basket update.

**B. ALTHA does not support this proposal because CMS has not based its decision on current and adequate data that supports its proposed adjustment**

CMS does not base the proposed update to the standard Federal rate on verifiable or relevant data. CMS calculated the update factor by subtracting from the estimated increase in the market basket (3.5 percent), the difference between "observed" increases in the case-mix (1.9 percent), minus what CMS deems the real case-mix increase (1.0 percent). To find the real case-mix increase, or the portion CMS attributes to a rise in the treatment of resource intensive cases, CMS relies on an estimate found in a RAND study of IPPS hospitals published in 1991 and conducted on claims data from 1987 to 1988. CMS does not adequately explain how these old data are translatable to a different provider type 20 years later. Unless CMS has actually studied case-mix in LTACHs, it cannot know what the real case-mix changes have been. One of the standards CMS adheres to in using price indexes in the market basket is the relevance of that index to the type of provider. Using case-mix changes that were calculated on data from 20 years ago and on another provider-type cannot possibly be viewed as meeting that standard.

**C. ALTHA does not support payment cuts to LTACHs when LTACHs are facing negative operating margins**

ALTHA notes that at the January MedPAC meeting, analysts estimated LTACH margins for FY 2008 would be between -1.4 and -0.4 percent, depending on how hospitals-within-hospitals respond to the 50 percent threshold for admissions from a host hospital.<sup>1</sup> These margins include the changes from the MMSEA. Last year, MedPAC also estimated LTACH margins close to zero percent.

In past regulations, CMS has justified making the case-mix adjustment because LTACHs had higher operating margins. In the face of negative margins, CMS should be consistent and provide LTACHs with a full market basket update. By providing less than a full market basket update, CMS will be reimbursing LTACHs at a rate lower than their costs. Curiously, CMS does not publish a margin estimate in this regulation, and does not use its margin estimate to justify making a case-mix adjustment. ALTHA believes it is not rational for CMS to update payments below costs in a year when providers are operating with negative margins. ALTHA feels that this proposal would put patient access to LTACH services further into jeopardy.

**Recommendation.** ALTHA believes that a full market basket update of 3.5 percent is warranted and required under CMS' own regulatory language. ALTHA also believes CMS is not following the purpose of the RPL market basket update, which is to adequately reimburse LTACHs for changes in price inflation, and thus is failing to follow its own regulatory requirements. ALTHA requests, therefore, that CMS provide the full market basket update in the final rule.

**(3) The percentage increase to the standard federal rate should be applied to the federal rate established by CMS for RY 2008 in order to fully adjust for the increase in prices of the market basket of goods and services**

**Issue.** Section 114(e) of the MMSEA maintains the base rate for the last quarter of RY 2008 (April 1, 2008, to June 30, 2008) at the base rate for RY 2007. The legislation does not define the term base rate. Two provisions work in tandem to effect this change. First, Section 1886(m) of the Social Security Act is amended to maintain the same base rate for RY 2008. Second, Section 114(e)(2) of the MMSEA delays the effective date of this provision by stating that it will not apply to discharges during the first three quarters of RY 2008 (July 1, 2007, to March 31, 2008).

CMS' interpretation of the MMSEA is that Congress was referring to the unadjusted LTACH PPS standard federal rate when using the term base rate. Thus, CMS concludes that the first provision, amending Section 1886(m) of the Social Security Act, reverses the update CMS established in the final rule for the annual payment rate update for RY 2008 (\$38,356.45). CMS then bases its proposal to update the RY 2009 standard federal rate using the RY 2007 standard federal rate (\$38,086.04). The result is that CMS now proposes to update the *revised* RY 2008 standard federal rate of \$38,086.04 by 2.6 percent for Medicare discharges occurring on or after July 1, 2008, through September 30, 2009 (RY 2009), rather than update the previously established RY 2008 standard federal rate of \$38,356.45.

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<sup>1</sup> MedPAC analysts' presentation. January 10, 2007  
[http://medpac.gov/transcripts/0108\\_LTCH\\_DK\\_pres.pdf](http://medpac.gov/transcripts/0108_LTCH_DK_pres.pdf)

**Comment.** The MMSEA did not eliminate the update to the standard federal rate for RY 2008. The unquestionable effect of Section 114(e) of the MMSEA is to provide for a reduction in the base rate for only the last three months of RY 2008. Assuming that Congress was referring to the standard federal rate when it used the term base rate, CMS incorrectly ignores the provision at Section 114(e)(2) of the MMSEA when proposing to use the RY 2007 standard federal rate to update the RY 2009 standard federal rate. As discussed above, that provision clearly limited the period impacted by this part of the legislation to only the last quarter of RY 2008. The intent of Congress was to induce this very brief reduction in LTACH payments to help maintain the budget-neutral impact of Section 114 overall, not to remove an entire year's payment update from the update formula used to determine payments in all future LTACH PPS rate years.

The three-month freeze on the standard federal rate is a distinct act of Congress that should not be applied beyond the end of RY 2008. The amendment to Section 1886(m) of the Social Security Act states that “for discharges occurring **during the rate year ending in 2008** for a hospital, the base rate **for such discharges** for the hospital shall be the same as the base rate for discharges for the hospital occurring during the rate year ending in 2007” (emphasis added). Even when looking at this provision alone, it is clear that Congress did not eliminate the update to the RY 2008 standard federal rate for all future rate years. And when the second provision at Section 114(e)(2) of the MMSEA is taken into consideration—which must be done to properly understand the legislation—it is evident that the update for the last three months of RY 2008 was eliminated solely with respect to discharges during those three months.

The amendment to Section 1886(m)(2) of the Social Security Act is titled “Update for Rate Year 2008.” This title, as well as the plain meaning of the language of the subsection, shows that Congress did not provide for an ongoing change to the standard federal rate. The MMSEA was enacted on December 29, 2007, which was halfway through RY 2008. By limiting the base rate during the last three months of the rate year (April 1, 2008, to June 30, 2008), the legislation also avoided any retroactive effect. If CMS finalizes its proposal to ignore the full year update to the RY 2008 standard federal rate when calculating the update for RY 2009, that final rulemaking *will* have a retroactive effect. It will eliminate the prior, full-year update for RY 2008 in every subsequent update. Although CMS is not recouping RY 2008 payments, the retroactive effect of such a rule is equally, if not more, harmful to LTACHs because it will have a compounded effect with each passing year. This is contrary to CMS' own policy of not engaging in retroactive rulemaking.

According to CMS, the annual update to the standard federal rate is designed “to adjust for the most recent estimate of the increase in prices of an appropriate market basket of goods and services for LTACHs.”<sup>2</sup> CMS now proposes an adjustment in the RY 2008 standard federal rate “based on the best available data and policies established in that final rule.”<sup>3</sup> CMS provides the following description of its effort to use the “best available data” to update the RY 2009 rate:

To determine a 15-month market basket update for RY 2009, we calculate the 5-quarter moving average index level for July 1, 2008 through September 30, 2009 and the 4-quarter moving average index

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<sup>2</sup> 73 Fed. Reg. 5342, 5360 (Jan. 29, 2008).

<sup>3</sup> *Id.* at 5361.

level for July 1, 2007 through June 30, 2008. The percent change in these two values represents the proposed 15-month market basket update.<sup>4</sup>

Based on this analysis, the projected 15-month market basket estimate for RY 2009 is 3.5 percent. Accordingly, CMS proposes to update the federal rate by the market basket estimate of 3.5 percent less an adjustment of 0.9 percent to account for what CMS believes was an increase in case-mix in FY 2006. This analysis leads to the proposal to update the standard federal rate by 2.6 percent for RY 2009.

This proposed update to the rate is fundamentally flawed because CMS fails to consider the impact of the four-quarter moving average index level for July 1, 2006, through June 30, 2007. In the annual update to the RY 2008 LTACH PPS, CMS adjusted the standard federal rate based on the most recent estimate of the market basket of 3.2 percent less an adjustment to account for changes in coding practices of 2.49 percent. The resulting update to the rate was 0.71 percent. Now, CMS proposes to ignore the 3.2 percent increase in the market basket during RY 2008. This approach to establishing the market basket fails to appreciate the data CMS has received from its contractor, Global Insight, Inc, as well as its own analysis.

The consequences of failing to base the market basket update on the original RY 2008 standard federal rate of \$38,356.45 are magnified by the fact that CMS is proposing to extend the next rate year by three months, which will make the RY 2009 rate effective through September 30, 2009. Furthermore, since CMS provided no increase in the federal rate for RY 2007, the proposed 2.6 percent increase to the RY 2007 rate is an increase to the standard federal rate that was in effect on July 1, 2006, a full two years prior to the beginning of RY 2009. In other words, the standard federal rate that CMS proposes to be effective on September 1, **2009**, will be a mere 2.6 percent higher than the standard federal rate in effect on July 1, **2006**, if the update is adopted as proposed. This update fails to account for the market basket increase that will occur, and has already occurred, over this 39-month period. CMS must not engage in this type of punitive, retroactive rulemaking when Congress has provided express statutory authority for LTACHs and a PPS that reasonably reimburses LTACHs for the cost of care.

***Recommendation.*** ALTHA recommends that CMS apply the update to the standard federal rate to the RY 2008 amount of \$38,356.45.

#### **(4) CMS should revise the fixed loss amount of \$21,199**

***Issue.*** CMS estimates the fixed-loss amount for RY 2009 to be \$21,199. This amount is calculated to ensure that the outlier pool of funds equals 8 percent of total spending on LTACH services. CMS adjusts the outlier amount each year based on new spending projections, which reflect payment rates, volume, and case-mix changes.

***Comment.*** ALTHA is concerned that CMS calculated the fixed-loss amount without including the effects of all recent policy changes that are now current law but were not implemented in this regulation.

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<sup>4</sup> *Id.* at 5352.

The MMSEA made several program changes that are expected to impact overall spending for LTACH services in the Medicare program. These changes, which are effective for three years, include: the elimination of one type of short-stay outlier case; the freeze of the 25 percent rule for co-located LTACHs at a 50 percent threshold (75 percent threshold for certain co-located LTACHs); and the elimination of the 25 percent rule for freestanding LTACHs. The agency does not discuss these changes extensively in this regulation, and states that policies not implemented here would be discussed in future regulations.

ALTHA is concerned that the effects on total payments to LTACHs of both the elimination of one kind of short-stay outlier case and the changes to the 25 percent rule for three years were not included in CMS' calculations for total revenues in this regulation and therefore not included in the calculation of the fixed-loss amount. Because both policies are expected to increase payments to LTACHs, these decisions should be factored in CMS' estimate of total payments to LTACH in RY 2009 and also would affect the calculation of the fixed-loss amount in this year.

ALTHA expects that if CMS were to incorporate these policy changes in its estimate of total LTACH PPS payments for RY 2009, the fixed-loss amount would decrease, holding other factors constant. This is because the outlier pool would increase in size; it would be 8 percent of a larger total payments amount. Because the outlier pool would have more money in it once the MMSEA policy changes were incorporated, CMS would lower the fixed-loss amount so that more cases would qualify as high-cost outliers. The result would see the entire high-cost outlier pool of funds spent.

ALTHA is also concerned that CMS is raising the fixed-loss amount even without including the impact on revenues of the MMSEA provisions. Because CMS is estimating per discharge payments will increase in RY 2009, the fixed-loss amount should decrease relative to the previous year.<sup>5</sup> As stated above, the fixed-loss amount should decrease when the size of the outlier pool increases (holding other factors constant), in order to ensure that more cases qualify for high-cost outlier status and all funds in the outlier pool are distributed.

In previous years' regulations, CMS has increased the fixed loss to maintain high-cost outlier payments at 8 percent of total payments when the agency has made policy changes expected to reduce payments to LTACHs. In the final rule for RY 2007, CMS states that the "increase to the fixed-loss amount had a direct correlation to our estimated decrease in aggregate LTACH PPS payments for RY 2007..."<sup>6</sup> Similarly, for RY 2008 CMS explained the reason that the fixed-loss amount increased from \$14,887 to \$22,954<sup>7</sup> was the:

change in the fixed-loss amount is due to the projected decrease in estimated aggregate LTACH PPS payments that is expected to result from the revision to the SSO policy under § 412.529 (discussed in greater detail in section V.A.2. of this preamble), in conjunction with the changes to the area wage adjustment (discussed in greater detail in section IV.D.1. of this preamble) and the changes to the LTC-DRG relative weights for

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<sup>5</sup> Table 9 of the proposed regulation states that the estimated per case payment for RY 2009 will be \$33,092 compared to \$32,166 in RY 2008.

<sup>6</sup> Pg. 210 of html version of final rule for RY 2007

<sup>7</sup> In subsequent regulation, CMS revised the fixed-loss amount from \$22,954 to \$20,738 because the agency had corrected an error in its payment simulation model.

FY 2007 (as discussed in the FY 2007 IPPS final rule (71 FR 47971 through 47994)).<sup>8</sup>

Thus, the reason for the \$8,000 (corrected to \$5,000) increase in the fixed-loss amount was a result of the change in payments for VSSOs that reduced overall LTACH payments; since the elimination of that policy by the MMSEA will increase payments, the fixed-loss amount must decrease relative to the current level.

The table below documents how changes in estimated payment levels have affected the fixed-loss amount.<sup>9</sup>

	Estimated Average Payment Per Case	Estimated Payment Change	Fixed-Loss Amount
<b>RY 2006</b>	\$33,208	---	\$10,501
<b>RY 2007</b>	\$31,963	-3.7 percent	\$14,887
<b>RY 2008</b>	\$32,562	-1.2 percent	\$20,738
<b>RY 2009 proposed</b>	\$33,092	2.9 percent	\$21,199

Given the mechanical nature of the methodology for calculating the high-cost outlier pool amount and the fixed-loss threshold, ALTHA believes CMS has made an error in calculating the proposed RY 2009 fixed-loss amount. The fixed-loss amount should be lower than the 2008 amount, because payments are expected to increase in 2009 relative to 2008, and increased expected payments for cases that would have been subject to the VSSO policy or the 25 percent rule would be even less likely to qualify for high-cost outlier status. According to our analysis, the fixed-loss amount should be approximately \$300 less than CMS anticipated.

**Recommendation.** For the reasons discussed above, CMS should recalculate the proposed increase to the fixed-loss amount for RY 2009. ALTHA believes there are multiple errors in the CMS calculation of the fixed-loss amount and that its implementation will result in incorrect reductions in payments to LTACHs. ALTHA believes the fixed-loss amount should be approximately \$300 less than CMS' initial calculations. ALTHA recommends that CMS revise its amount taking into account all policy changes that will impact payments in RY 2009 and inform stakeholders of the new calculation as soon as possible.

**(5) ALTHA concurs with CMS' proposed methodology for setting wage indices in areas where there are no IPPS hospitals**

**Issue.** CMS proposes to establish a method of setting LTACH wage indices in areas where there are no IPPS hospitals. There are not currently areas where a LTACH exists without an acute hospital so CMS estimates that implementing this proposal would not affect any current LTACH providers.

**Comment.** ALTHA agrees that it is unlikely a LTACH would operate in an area without an acute care hospital that could supply wage data, as IPPS hospitals are a common

<sup>8</sup> Federal Register / Vol. 72, No. 91 / Friday, May 11, 2007 / pg. 26,899.

<sup>9</sup> Source: Impact tables from RY 2007-2009 regulations. 2009 values are proposed.

referral source for LTCHs. ALTHA concurs with CMS that it is practical to prepare for this unlikely scenario, and deems the proposed methodology as reasonable.

**Recommendation.** ALTHA recommends that CMS finalize this methodology as described in the proposed rule.

**(6) CMS should not make a one-time BNA**

**Issue.** In past rulemakings, CMS has provided for the possibility of making a one-time prospective adjustment to the LTACH PPS rates before the end of the transition period (October 1, 2006). This provision would be made to correct any error CMS made in estimating the federal rate in the first year of LTACH PPS that would lead to higher or lower payments under the PPS versus TEFRA and would be perpetuated into later years. In this proposed rule, CMS lays out a proposed methodology for making a one-time prospective BNA even though the MMSEA prohibits CMS from making this adjustment through December 29, 2010.

**Comment.** The major points of ALTHA's response to this policy proposal are outlined below.

- A. CMS is not specifically authorized by the statute to make a one-time BNA, nor is CMS obligated to make such an adjustment
- B. By using the best available data at the time in rate setting in year one, CMS has fulfilled its responsibility to achieve budget neutrality
- C. ALTHA disagrees with CMS's proposed changes to the one-time BNA language in the code of federal regulations
- D. Making a BNA violates the principals of a prospective payment system
- E. Annual refinements to the LTACH PPS have addressed previous errors CMS made in rate setting
- F. Complete comments on the proposed adjustment are not possible unless CMS releases data used to calculate the adjustment amount
- G. There are some errors in the methodology ALTHA would like to see addressed

**A. CMS is not specially authorized by statute to make a one-time BNA, nor is CMS obligated to make such an adjustment**

ALTHA maintains that the decision whether to make a one-time BNA is completely discretionary for CMS. We note that the concept of a one-time BNA is not found in any statute pertaining to LTCHs. Rather, CMS created this adjustment by regulation.

The discretionary nature of the one-time BNA is evident in the language of the regulation. Pursuant to the regulation, the Secretary of the Department of Health and Human Services "may" make a "one-time prospective adjustment." Indeed, the March 22, 2002, proposed rule had stated that the Secretary "will" make a "one-time

prospective adjustment” but the proposed rule was modified to “may” when issued in final.<sup>10</sup>

It is a well-established rule of statutory and regulatory construction that use of the word “may” is properly read as creating discretion, whereas use of the words “will” or “shall” is properly read as imposing a requirement.<sup>11</sup> Consequently, it is undisputed that the regulation is discretionary and does not require CMS to act.

CMS also recognizes the discretionary nature of the regulation repeatedly throughout its *Federal Register* issuances addressing the one-time BNA. For example, in the August 30, 2002, final rule adopting the regulation, CMS states that, pursuant to its “broad authority” under the statute, CMS has provided for the “possibility” of making the one-time BNA.<sup>12</sup> A more recent example is found in the May 12, 2006, final rule when CMS acknowledges that the one-time BNA may not be needed. In particular, CMS states as follows:

To the extent of our review of FY 2003 LTCH data (which will include but, is not limited to changes in case-mix) show that, if by coincidence after updating the federal rate by zero percent for RY 2007, the standard federal rate is appropriate, it is possible that any further adjustment to the federal rate may be unnecessary.<sup>13</sup>

Lastly, in the most recent LTACH PPS final rule published on May 11, 2007, CMS explains that it will conduct an “evaluation” of the “possibility” of making the one-time BNA:

We plan 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 PPS rates provided for at § 412.523(d)(3) after the conclusion of the 5-year transition to 100 percent of the federal rate under the LTCH PPS.<sup>14</sup>

ALTHA finds that CMS acknowledges the discretionary nature of the decision whether to make the one-time BNA, and that CMS cannot claim it is required to make such an adjustment.

#### **B. By using the best available data at the time in rate setting in year one, CMS has fulfilled its responsibility to achieve budget neutrality**

ALTHA believes CMS’ budget-neutrality obligation has been met using the best available data, thus making the one-time BNA unnecessary. Section 123 of the Balanced Budget Refinement Act of 1999 (BBRA) mandates that the LTACH PPS “maintain budget neutrality”:

<sup>10</sup> 67 Fed. Reg. 13,416, 13,484 (Mar. 22, 2002); 67 Fed. Reg. 55,954, 56,052 (Aug. 30, 2002).

<sup>11</sup> *Dickson v. Sec’y of Def.*, 68 F.3d 1396 (D.C. Cir. 1995); *Marshall County Health Care Auth. v. Shalala*, 988 F.2d 1221 (D.C. Cir. 1993); *In re 1900 M Restaurant Assoc., Inc. v. United States*, 352 B.R. 1 (D.C. Cir. 2006); *Strass v. Kaiser Found. Health Plan*, 744 A.2d 1000 (D.C. 2000).

<sup>12</sup> 67 Fed. Reg. at 56,036 (emphasis added).

<sup>13</sup> 71 Fed. Reg. 27,798, 27,820 (May 12, 2006).

<sup>14</sup> 72 Fed. Reg. 26,870, 26,900 (May 11, 2007) (emphasis added).

**(a) Development of System:**

**(1) In general:** The Secretary of HHS shall develop a per discharge prospective payment system for payment for inpatient hospital services of long-term care hospitals described in section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. § 1395ww(d)(1)(B)(iv)) under the Medicare program. Such system shall include an adequate patient classification system that is based on diagnosis-related groups and that reflects the differences in patient resource use and costs, and ***shall maintain budget neutrality***.<sup>15</sup>

Although brief, the legislative history of Section 123 clarifies what Congress meant by its mandate that “[s]uch system shall include an adequate patient classification system that is based on diagnosis-related groups and that reflects the differences in patient resource use and costs, and ***shall maintain budget neutrality***.”<sup>16</sup> The Conference Report specifically states that this provision provides for a LTACH PPS “which ***would be implemented*** in a budget-neutral fashion.”<sup>17</sup> The words “would be implemented” connote a prospective basis. Given the legislative history, it is clear that Congress meant for budget neutrality to be addressed prospectively at the mandated date of implementation—October 1, 2002.<sup>18</sup>

Indeed, CMS did just that when it used the best available data to craft and implement the LTACH PPS in the August 30, 2002, Final Rule pursuant to 42 C.F.R. § 412.523(d)(2). Section 412.523(d)(2) provides:

**(d) Adjustments to the standard federal rate.** The standard federal rate described in paragraph (c)(3) of this section will be adjusted for –

\* \* \*

**(2) Budget neutrality.** ***CMS adjusts the federal prospective payment rates for FY 2003*** so that aggregate payments under the prospective payment system are estimated to equal the amount that would have been paid to long-term care hospitals under Part 413 of this subchapter without regard to the prospective payment system implemented under this subpart, excluding the effects of sections 1886(b)(2) and (b)(3) of the Act.<sup>19</sup>

An additional one-time modification to the LTACH PPS rates six years after the LTACH PPS has been implemented, and based generally on budget neutrality, contradicts congressional intent and is unnecessary since budget neutrality at the time of implementation used the best available data.

<sup>15</sup> Balanced Budget Refinement Act of 1999 (BBRA), Pub. L. No. 106-113, § 123(a)(1), 113 Stat. 1501A-324, 331 (1999) (emphasis added).

<sup>16</sup> BBRA § 123(a)(1) (emphasis added).

<sup>17</sup> H.R. Rep. No. 106-479, at 859 (1999) (Conf. Rep.) (emphasis added).

<sup>18</sup> Even if “implementation” were to reference the five-year transition period created by CMS, this statutory provision does not provide legal authority for a look-back to actual costs and actual payments.

<sup>19</sup> 42 C.F.R. § 412.523(d)(2) (emphasis added).

In this regard, under 42 C.F.R. § 412.523(a)(1), CMS requires use of “the **best** Medicare data available” in calculating the initial LTACH PPS rates:

(a) **Data used.** To calculate the initial prospective payment rates for inpatient hospital services furnished by long-term care hospitals, CMS uses –

(1) **The best Medicare data available;** and

(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.<sup>20</sup>

CMS has recognized that it has satisfied this regulatory obligation, particularly as it relates to budget neutrality. For example, in the March 22, 2002, proposed rule, CMS states: “We are proposing to establish a standard federal payment rate based on the **best available** LTCH cost data.”<sup>21</sup> There are several instances in this proposed rule where CMS describes its use of the best available data in setting the standard federal rates in year one. For example, CMS discusses its use of the best available data in the August 30, 2002, final rule:

“We designed the prospective payment system for LTCHs with the following objectives:

To base the prospective payment system on an analysis of the **best information and data available** . . .”<sup>22</sup>

“We have established a standard Federal payment rate based on the **best available LTCH cost data**.”<sup>23</sup>

In addition, CMS relied on the best available data in establishing budget neutrality for year one payments:

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 LTCH prospective payment system were not implemented. Our methodology for estimating payments for purposes of the budget neutrality calculations uses the **best available data** and necessarily reflects assumptions.<sup>24</sup>

As CMS has conceded, the best data available is what CMS used initially for the August 30, 2002, Final Rule, and this maintains the congressional intent for budget neutrality.

CMS further explains several times throughout the years since implementation that CMS satisfied its budget-neutrality obligation in year one. For example, CMS has asserted that the statutory mandate for budget neutrality applies only to the first year of the implementation of the LTACH PPS:

<sup>20</sup> 42 C.F.R. § 412.523(a)(1) (emphasis added).

<sup>21</sup> 67 Fed. Reg. at 13,437 (emphasis added).

<sup>22</sup> 67 Fed. Reg. at 55,956 (emphasis added).

<sup>23</sup> *Id.* at 55,983 (emphasis added).

<sup>24</sup> 67 Fed. Reg. at 13,472 (emphasis added).

We believe the statutory mandate for BN applies only to the first year of the implementation of the LTCH PPS such that estimated payments in the first year of the PPS were projected to equal payments that would have been paid for operating and capital-related costs of LTCHs had this new payment system not been enacted.<sup>25</sup>

In another instance, CMS states that it met budget neutrality in year one when explaining why it will not adjust the LTC-DRG classifications for budget neutrality:

We do not believe that section 123 of the Pub. L. 106-113 requires that the annual update to the LTC-DRG classifications and relative weights maintain budget neutrality. ***We believe we have satisfied the budget neutrality requirement of section 123 of the Pub. L. 106-113 by establishing the LTCH PPS Federal rate for FY 2003 under § 412.523(d)(2) so that aggregate payments under the LTCH PPS are projected equal to estimated aggregate payments under the reasonable cost-based payment system if the LTCH PPS were not implemented.*** Therefore, we disagree with the commenters that an adjustment to the FY 2005 LTC-DRG relative weights or to the LTCH PPS Federal rate is required as a result of the annual update to the LTC-DRGs under § 412.517 for FY 2005. Accordingly, we have updated the LTC-DRG classifications and relative weights for FY 2005 (as shown in Table 11 of Addendum to this final rule) without an adjustment for budget neutrality.<sup>26</sup>

Thus, CMS concedes that CMS has met its budget-neutrality obligations under 42 C.F.R. § 412.523(d)(2).

### **C. ALTHA disagrees with CMS's proposed changes to the one-time BNA regulation**

In the proposed rule, CMS proposes to replace the current regulation for the one-time BNA at 42 C.F.R. § 412.523(d)(3) with a new regulation. The current regulation states the following:

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 on or before July 1, 2008 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.

CMS now proposes to replace this regulation with the following new regulation:

The Secretary reviews payments under this prospective payment system and may make a one-time prospective adjustment to the long-term care

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<sup>25</sup> 72 Fed. Reg. at 26,871-26,872.

<sup>26</sup> 69 Fed. Reg. 48,916, 48,999-49,000 (Aug. 11, 2004) (emphasis added).

hospital prospective payment system rates no earlier than December 29, 2010, so that the effect of any significant difference between the data used in the original computations and more recent data to determine budget neutrality is not perpetuated in the prospective payment rates for future years.<sup>27</sup>

ALTHA agrees with CMS's proposal to specify in the regulation that a one-time budget neutrality adjustment to LTACH PPS rates cannot be made prior to December 29, 2010, pursuant to MMSEA section 114(c)(4). Under the same section of the legislation, Congress also prohibits CMS from making such a one-time adjustment for this 3-year period under any similar provision.

However, ALTHA disagrees with the additional changes now being proposed to the regulation for the one-time BNA because: (1) they arbitrarily dispense with the original concept of an adjustment to rectify a difference between actual and estimated payments in year one of the LTACH PPS; (2) they are overly broad and do not clearly address the policy goal articulated by CMS when the LTACH PPS was created, or in this proposed rule; and (3) they unfairly and unjustifiably do not specify a date certain after which time CMS would no longer be able to implement a one-time BNA to the LTACH PPS.

First, the proposed changes to this regulation arbitrarily dispense with the original concept of an adjustment to rectify a difference between actual and estimated payments in year one of the LTACH PPS. CMS has consistently stated that a one-time BNA may be needed to correct a significant difference between estimated and actual payments in the first year of prospective payment, and that the statutory mandate for budget neutrality applies only to the first year of the implementation of the LTACH PPS. For example, CMS stated that:

We believe the statutory mandate for BN applies only to the first year of the implementation of the LTCH PPS such that estimated payments in the first year of the PPS were projected to equal payments that would have been paid for operating and capital-related costs of LTCHs had this new payment system not been enacted.<sup>28</sup>

The statutory mandate for budget neutrality in the LTACH PPS comes section 123 of the Balanced Budget Refinement Act of 1999 (BBRA), which called for the establishment of an LTACH PPS that "shall maintain budget neutrality."<sup>29</sup> CMS adopted regulations permitting an adjustment to the standard Federal rate in the final rules implementing LTACH PPS, including a one-time prospective adjustment on or before October 1, 2006 (CMS later extended that deadline by nearly two years to July 1, 2008).

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."<sup>30</sup>

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<sup>27</sup> 73 Fed. Reg. 5342, 5384 (to be codified at 42 C.F.R. § 412.523(d)(3)).

<sup>28</sup> 72 Fed. Reg. at 26,871-26,872 (May 11, 2007).

<sup>29</sup> Balanced Budget Refinement Act of 1999, Pub. L. No. 106-113, 113 Stat. 1501A-331.

<sup>30</sup> 71 Fed. Reg. 27825 (May 12, 2006).

Therefore, throughout the rulemaking process, CMS consistently states that the one-time adjustment of 42 C.F.R. 412.523(d)(3) would only be used to adjust the Federal rate in the event payments under LTACH PPS in FY 2003 (year one) differed substantially from payment under TEFRA.<sup>31</sup> CMS's proposal to remove the reference to the first year of the LTACH PPS from the regulation altogether directly conflicts with the agency's insistence, year after year, that the one-time BNA would only be used to address a significant difference between the estimated and actual FY 2003 LTACH PPS rates.

Second, the proposed changes to the regulation are overly broad and do not clearly address the policy goal articulated by CMS when the LTACH PPS was created, or in this proposed rule. The current regulation limits the scope of a one-time BNA to "any significant difference between **actual payments** and **estimated payments** for the **first year** of the long term care hospital prospective payment system" (emphasis added). In contrast, the proposed regulation broadens the scope of a one-time BNA to "any significant difference between the **data used in the original computations** and **more recent data to determine budget neutrality**" (emphasis added). CMS's rationale for these changes is stated in the proposed rule as follows:

As we have just discussed, we believe after a thorough evaluation of the currently available data in the light of this policy objective, that the most appropriate methodology for evaluating an adjustment to the original budget neutrality adjustment does not involve comparing the payments estimated in the original calculations against the "actual payments \* \* \* for the first year," strictly speaking. Rather, as just discussed, considerations of consistency and other factors suggest that the most appropriate comparison would employ an estimate of FY 2003 LTCH PPS payments based on the same set of discharges (from FY 2002) which are the basis for the best estimate of what would have been paid in FY 2003 under the TEFRA system. As a result of this methodological determination, under the broad authority of section 123 of the BBRA, as amended by section 307(b) of BIPA, to make appropriate adjustments to the LTCH PPS, we are proposing to revise § 412.523(d)(3) to reflect the preferred methodology more clearly.<sup>32</sup>

But CMS has not proposed a revised regulation that reflects this "preferred methodology" more clearly. Even though ALTHA is not in a position to meaningfully comment on this new methodology now being proposed for calculating the one-time BNA (for the reasons discussed elsewhere in this letter), ALTHA can comment that the changes to the regulation at 42 C.F.R. § 412.523(d)(3) do not reflect this discussion of the new methodology. Significantly, CMS states that its methodology still looks at FY 2003 LTACH PPS payments, as CMS has previously stated in its rulemakings; however, the proposed regulation makes no mention of FY 2003 or the first year of the LTACH PPS. Moreover, the key phrases in the proposed regulation – "data used in the original computations" and "more recent data to determine budget neutrality" – are so vague and imprecise that it is almost impossible for a reasonable person to know their meaning. The explanation in the preamble does not rectify this problem. The new regulation, as

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<sup>31</sup> 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).

<sup>32</sup> 73 Fed. Reg. 5342, 5355-56.

proposed, is simply too vague to put LTACH hospitals on notice of this change in policy or how this regulation will be used.

Third, the proposed regulation unfairly and unjustifiably does not specify a date certain after which time CMS would no longer be able to implement a one-time BNA to the LTACH PPS. Until now, the one-time BNA regulation specified a date in the near future, based upon a stated rationale that gave CMS a clear timeframe for reaching a determination as to whether a one-time BNA was necessary and to implement that adjustment, if appropriate. At first, the regulation stated the adjustment could be made on or before October 1, 2006. CMS later extended that deadline by nearly two years to July 1, 2008. ALTHA has consistently opposed the need for this one-time BNA, and the lack of an end-date in this proposed regulation is objectionable because it leaves LTACHs in a perpetual state of uncertainty. Unless the one-time BNA is removed from the regulations altogether, CMS should specify a fixed end date for determining whether to implement this adjustment, and that end date should be stated in the regulation.

#### **D. Making a BNA violates the principals of a prospective payment system**

Prior to the LTACH PPS, no historical Medicare program prospective payment system has had a similar one-time BNA provision.<sup>33</sup> While there have been budget-neutrality requirements in these other prospective payment systems, no one-time adjustment occurred years later based on actual payments and actual costs in year one of that prospective payment system. These other budget-neutrality requirements were met through reliance on estimates similar to 42 C.F.R. § 412.523(d)(2). The reason being is that any look-back is inconsistent with the basic tenets of a prospective payment system because there are behavior changes occurring during implementation that make any such look-back at actual costs or payments inappropriate.

For example, in 1983, CMS implemented the first prospective payment system for inpatient hospitals that were not specialty hospitals. At that time, CMS recognized that implementing a PPS would necessarily cause changes in hospital behaviors and that it would be inappropriate to subsequently take these changes into account for budget-neutrality purposes:

*Hospital Impact--*During its first two years, aggregate payments under the prospective payment system will be adjusted, in accordance with Section 1886(e)(1) of the Act, to be "budget neutral;" that is, so that aggregate payments under the prospective payment system, including outlier payments, exceptions, and adjustments, will be neither more nor less than the estimated payment amounts to affected hospitals that would have resulted under the Social Security Act as in effect before April 20, 1983. During the three years of the transition period, payment rates to about 5,500 hospitals will be a blend of hospital-specific amounts based on each hospital's cost experience, and federal amounts based on the averaged experience of hospitals. (See Section III. C. of the preamble.) The initial impact of the prospective payment system will be like the impact that would

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<sup>33</sup> Aside from the LTCH PPS, CMS did promulgate a regulation with a similar one-time adjustment for the psychiatric hospital prospective payment system subsequent to the inpatient psychiatric hospital PPS. We similarly question the legal authority for that regulation.

have occurred to affected hospitals under the TEFRA provisions, because the hospital-specific portion of the first year's rate will be set at 75 percent of the TEFRA target amount. However, this impact will gradually change during the transition period, as the hospital-specific portion of the payment rate will be set at an increasingly lower percentage of each fiscal year's TEFRA target amounts. **To correspond to the budget neutrality provision of the law, this estimated impact assumes no change in hospitals' economic behavior in response to this system.**

***However, prospective payment systems will change the economic incentives that influence a hospital's decisions in the use of resource inputs for each case. The profit potential inherent in this system alone should encourage hospitals to begin changing their behavior to decrease their operating costs.*** We believe that individual hospitals with lower current year operating costs per case will probably do better under this system than hospitals that cannot reduce or control these costs.<sup>34</sup>

Consequently, estimates are used at the time of implementation precisely because a prospective payment system is supposed to change behavior in year one.

More recently in connection with IPPS, CMS stated the following:

With regard to alleged errors in FYs 1999 through 2007, our calculation of budget neutrality in past fiscal years is not within the scope of this rulemaking. Even if errors were made in prior fiscal years, we would not make an adjustment to make up for those errors when setting rates for FY 2008. ***It is our longstanding policy that finality is critical to a prospective payment system.*** Although errors in ratesetting are inevitable, we believe the need to establish final prospective rates outweighs the greater accuracy we might gain if we retroactively recomputed rates whenever an error is discovered.<sup>35</sup>

CMS also expected changes in behaviors by LTACHs when CMS implemented LTACH PPS such as changes in their admission, treatment, and discharge patterns:

The LTCH prospective payment system in this final rule was designed predominantly to encourage efficiency in the LTCHs treating patients requiring long-term hospital-level care. . . .

Although the regression analyses and simulations based on prior years' TEFRA data may seem to indicate that nearly half of LTCH cases will be paid on an adjusted per discharge amount, we believe this data analysis does not necessarily predict the future behavior of LTCHs operating under a prospective payment system. The data used in the analysis are a product or reflection of the practice patterns of hospitals that operate under the mechanisms of the TEFRA payment system, which are different from the principles of a prospective payment system. However,

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<sup>34</sup> 48 Fed. Reg. 39,752 (Sept. 2, 1983) (emphasis added).

<sup>35</sup> 72 Fed. Reg. 47,130, 47,330 (Aug. 22, 2007) (emphasis added).

these are the **best data available** upon which we can simulate LTCH behavior under the new LTCH prospective payment system. We believe that once the LTCH prospective payment system is implemented, the practice patterns of LTCHs will change. **We anticipate that hospitals will alter their admission, treatment, and discharge patterns.**<sup>36</sup>

Specifically, CMS acknowledges that the actual data it will use if it implements the one-time BNA reflects changes in LTACH behavior as a result of the LTACH PPS:

As also explained in that same final rule, we believe that postponing the deadline of the possible one-time prospective adjustment to the LTCH PPS rates provided for in § 412.523(d)(3) to July 1, 2008, would result in the availability of additional data generated under the LTCH PPS and, therefore, our decisions regarding a possible adjustment would be based on more complete and up-to-date data. **This data would be reflective of LTCH behavior in response to the implementation of the LTCH PPS.**<sup>37</sup>

Thus, CMS clearly recognizes that FY 2003 actual data reflects LTACH behavior changes resulting from implementation of the LTACH PPS. CMS' decision to ignore the effects these very behavior changes have on budget neutrality is inappropriate and contrary to congressional intent as reflected in the agency's own regulations.

When budget neutrality is based on the absence of a particular future event, then it can only be based on estimates in advance of that event because any actual data is tainted data that takes into account changes in behaviors caused by that future event. More specifically, what would have been paid under TEFRA during 2003 could never become "reality" or "actual" because the implementation of the LTACH PPS on October 1, 2002, destroyed that possibility and skewed and biased FY 2003 cost report data. Actual data from FY 2003 is unusable for determining what would have been paid under TEFRA had the LTACH PPS not existed because actual data from FY 2003 is colored by the existence of the LTACH PPS, which altered LTACH behavior as acknowledged by CMS. As such, the budget-neutrality mandate that LTACH PPS "be implemented" in a budget-neutral manner can only be based on estimates of what would have occurred in FY 2003 under TEFRA had there been no LTACH PPS. Thus, FY 2003 "actual" data is irrelevant to determining what would have occurred under TEFRA during FY 2003 and is contrary to achieving budget neutrality.

Indeed, by using actual FY 2003 cost/payment data that includes LTACH behavior changes, CMS would be building in a cost savings contrary to congressional intent that LTACH PPS be implemented in a budget-neutral manner. Such a cost savings also can be characterized as a recoupment for which there is no justification under a prospective payment system. This contradicts CMS' longstanding policy that "finality is critical to a prospective payment system."<sup>38</sup>

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<sup>36</sup> 67 Fed. Reg. at 55,999 (emphasis added).

<sup>37</sup> 72 Fed. Reg. at 26,902 (emphasis added).

<sup>38</sup> 72 Fed. Reg. at 47,330.

Yet, the regulation gives CMS the discretion to conduct a one-time BNA. This is not merely an adjustment. Instead, CMS characterizes the one-time BNA as a “comprehensive reevaluation” of CMS’ FY 2003 budget-neutrality estimates that we already know were based on the best data available:

For the reasons discussed in this section, we believe that we still do not have sufficient new data to enable us to conduct a **comprehensive reevaluation** of our FY 2003 BN calculations. Accordingly, in this final rule, we are not making a one-time BNA under § 412.523(d)(3) at this time.<sup>39</sup>

It is highly inappropriate after so many years of prospective payments to be looking backward at actual costs and actual payments in year one, even if any modification is made to a future rate.

Interestingly, when the regulation became final, the deadline for implementing the one-time BNA was “by October 1, 2006.”<sup>40</sup> In a subsequent *Federal Register* notice, CMS extended the deadline to “on or before July 1, 2008.”<sup>41</sup> The reason for the extension given by CMS was as follows:

We proposed to extend the deadline for making the possible one-time BNA until July 1, 2008 because we do not now believe that we will have sufficient data to make the determination by the current deadline of October 1, 2006. Specifically, as discussed in greater detail below in section V.D.6. of this preamble, we believe that only through a thorough analysis of the most comprehensive and accurate data from the first year of the implementation of the LTCH PPS for FY 2003 (including settled and fully audited cost reports) would we be able to reliably determine whether the one-time prospective adjustment to the standard Federal rate, which if issued would have an impact on all future payments under the LTCH PPS, should be proposed. Given the lag time required for typical cost report settlement involving submission, desk review, and in some cases an audit, which can take approximately 2 additional years to complete (and we expect to audit a number of LTCH cost reports for the purpose of this analysis), we do not believe that the October 1, 2006 deadline established in § 412.523(d)(3) is now reasonable or realistic. In fact, we believe that for providers whose FY 2003 cost reporting periods began at the end of FY 2003 (that is, September 2003) and ended in August 2004, we would be in possession of the most reliable cost report data indicating the actual costs of the Medicare program of the LTCH PPS during the year in which we established the Federal payment rate by July 2007 and any proposed correction, if finalized, could then be implemented on July 1, 2008.<sup>42</sup>

Unfortunately, over the years, the possibility that the one-time BNA will be made has created uncertainty as to the payments to LTACHs rather than finality. Whatever

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<sup>39</sup> 72 Fed. Reg. at 26,904 (emphasis added).

<sup>40</sup> 67 Fed. Reg. at 56,036.

<sup>41</sup> 71 Fed. Reg. at 27,845.

<sup>42</sup> 71 Fed. Reg. at 27,826.

actually occurred in year one has occurred—rents were paid, payrolls were paid—the time has passed to have any type of Medicare recoupment.

Indeed, the very decision of LTACHs to accept the transitional blended payment or to forego transition and accept 100 percent of the LTACH PPS rates illustrates just how inappropriate it would be to make the one-time BNA based on actual FY 2003 costs and payments. There are many factors that go into whether an LTACH would accept the transitional blended payment or to forego transition and accept 100 percent of the LTACH PPS rates. Obviously, one of the key issues is the standard federal rate. Another key issue is administrative convenience without necessarily maximizing payment. To now revisit and change future rates based on post-implementation LTACH behavioral responses under the guise of budget neutrality is inappropriate because a different final first year rate could have changed the LTACH response to the first year rates in the first instance. More specifically, if more LTACHs had chosen to transition to the LTACH PPS and receive the transitional blended rate in the first year, then the overall costs for the transition would have increased. CMS is now inappropriately attempting to achieve a backhanded cost savings at the expense of LTACH choice.

We also question why CMS had to wait this long for making its determination whether there has been a “significant difference” between estimates and actuals in year one. CMS already should have had some estimation if its initial assumptions were “significantly” off — either positively or negatively.

In light of the statutory and regulatory language, and CMS’ own acknowledgements above, the one-time BNA is no longer appropriate or needed. Any attempt now by CMS to implement the one-time BNA would be antithetical to budget neutrality. CMS’ claim that the actual costs and actual payments from FY 2003 will result in better accuracy/precision for budget-neutrality purposes is illusory.

In the absence of any compelling information, CMS should not exercise its discretion under the regulation because it would be grossly unfair, due to the significant passage of time, and it would be wholly inconsistent with the tenets of a **prospective** payment system. The entire premise of a prospective payment system is to rely on the best available data at the outset, to apply sound assumptions for any estimates that bring that data to a more current status and then look forward only.

#### **E. Annual refinements to the LTACH PPS have addressed previous errors CMS made in rate setting**

ALTHA finds that in previous payment policy changes, CMS has accounted for errors made in the calculation of LTACH PPS rates in the first year. ALTHA does not agree with CMS’ position that no payment adjustments made after the first year of the PPS have addressed errors in calculating payment rates. In fact, ALTHA finds that two payment adjustments have (1) addressed errors in the first year of the transition and (2) have lasting effects that ensure no errors are perpetuated into the future.

The first payment change that CMS made, and which addressed the question of budget neutrality in the first year of the LTACH PPS, was the transition BNAs that CMS prepared in the regulation governing the second year of the PPS. In that regulation, CMS stated that it had made errors in estimating the number of LTACHs that would move to the PPS in the first year (the agency had overestimated the number of hospitals

choosing to transition immediately to the PPS). CMS judged the effect of that error to be an overpayment relative to what would have been paid had the agency known those hospitals had stayed with the TEFRA-based system for the first year of the PPS. And at that time, CMS reduced payments across the board by 6 percent so that the transition to the PPS would be budget neutral. Now, while that reduction was ostensibly to ensure that the transition to the PPS was budget neutral in the second year, ALTHA maintains that that reduction is relevant to the question of the one-time BNA. That reduction is relevant because it 1) was a correction of calculation errors made in the first year of the PPS; 2) it was specifically an adjustment for overpayments for the first year of the PPS; and 3) it has had a permanent effect on payments to LTACHs.

According to final regulation for RY 2004, if the agency had accurately predicted the number of LTACHs making the transition to the PPS in the first year, it would have calculated a different base rate amount to maintain budget neutrality. To correct for that error, CMS increased the estimated transition budget neutrality adjustment of 5.1 percent to 6 percent for RY 2004. Since the agency made the adjustment for the first year error in the second year of the transition and because that adjustment is a permanent reduction in payments to LTACHs, the agency must acknowledge that adjustment in contemplating the need for a one-time BNA. If CMS were to make a one-time BNA, which ALTHA does not support, the agency must incorporate the value of this downward adjustment in its calculation because the first transition adjustment addressed the first year of the PPS and has had the effect of eliminating that payment error in future years.

Second, ALTHA believes that the case-mix adjustment that CMS made for RY 2007 to the market basket update also constitutes an adjustment for calculation errors in the payment rates for the first year of the PPS. In the regulation for RY 2007, CMS analyzed the FY 2002 and FY 2003 Medicare Provider Analysis and Review (MedPAR) files to calculate changes in case-mix. These data files contain LTACH cases from the first year of the PPS. CMS found evidence of apparent case-mix increase during the first year of the PPS that the agency had not accounted for in setting the base payment amount for that year. According to the agency's logic, if CMS had been able to accurately predict the amount of apparent case-mix change in advance of the first year of the PPS, the agency would have reduced the base payment amount. With the availability of data from that first year of the PPS, CMS did make such an adjustment in RY 2007. This downward adjustment of the base payment amount has had a permanent downward impact on reimbursement to LTACHs.

ALTHA maintains that this adjustment, like the transition period adjustment, must be included in CMS' decision-making about the necessity of making an additional and redundant downward one-time BNA. The downward adjustment to the market basket in 2007 is a cut that meets the one-time BNA threshold: 1) it reflects errors made in the first year of the PPS with regard to payment rates; and 2) it has the effect of eliminating those errors in subsequent years.

ALTHA maintains that a one-time BNA is neither mandatory nor warranted, and believes that CMS has indeed made corrections to the PPS payment rates that make a one-time BNA unnecessary. CMS must consider how the above payment changes have corrected for calculation errors in the first year of the PPS.

## **F. Complete comments on the proposed adjustment are not possible unless CMS releases data used to calculate the adjustment amount**

CMS has failed to provide data to support its proposal of making a one-time prospective adjustment to the LTACH PPS rates no earlier than December 29, 2010, in order to correct any error CMS made in estimating the federal rate in the first year of LTACH PPS. Without the ability to review the applicable data, the public cannot provide meaningful comments on this aspect of the proposed rule. It is well established that the legitimacy of a federal regulation may be called into question when the public is denied the ability to make meaningful comment.

Pursuant to the Administrative Procedures Act (the APA), federal agencies must “give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments.” 5 U.S.C. 553(c). Courts, including the D.C. Circuit, have consistently held that the public’s right to participate in the rulemaking process requires an agency to “provide sufficient factual detail and rationale for the rule to permit interested parties to comment meaningfully.”<sup>43</sup> In order for parties to offer meaningful support or criticism under the APA’s notice-and-comment rulemaking process, “it is especially important for the agency to identify and make available technical studies and data that it has employed in reaching the decisions to propose particular rules.”<sup>44</sup> If the federal agency relies on an outside study in promulgating a rule, the agency itself must first examine the methodology used to conduct the study.<sup>45</sup> Furthermore, the technical complexity of the analysis does not relieve the agency of the burden to consider all relevant factors and there “must be a rational connection between the factual inputs, modeling assumptions, modeling results and conclusions drawn from these results.”<sup>46</sup>

In an effort to provide meaningful comments on the proposal, ALTHA filed a request under the Freedom of Information Act (FOIA) for this data on April 25, 2007, asked for expedited processing of this request on November 9, 2007, and reiterated its request for this data on February 18, 2008. To this date, we have received no substantive response to our request. Among other information and data requested, we asked CMS to:

- Describe in detail the analytical methods used, including algorithms, formulas and specific data elements, for obtaining the different estimates of the budget neutrality total amount for the 2002 proposed and final rule.
- Provide the specific analytical methodology, including algorithms and formulas, indicating how the long-term acute care hospital base rate was adjusted by any market basket increase (or estimate market basket increase) and identify any other factors used and how such factors were used to adjust the base rate or estimated base rate) for each year 2002-2007.

We will need to review this data to properly evaluate and be in a position to meaningfully comment on the proposal. Submission of these comments does not obviate our need for this information or in any way validate the absence of this information in the notice of proposed rulemaking (NPRM).

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<sup>43</sup> *Florida Power & Light Co. v. United States*, 846 F.2d 765, 771 (D.C. Cir. 1988). See also *Home Box Office, Inc. v. FCC*, 567 F.2d 9, 35 (D.C. Cir. 1977); *United States v. Nova Scotia Food Products Corp.*, 568 F.2d 240, 251-52 (2d Cir. 1977).

<sup>44</sup> *Connecticut Light & Power Co. v. Nuclear Regulatory Com.*, 673 F.2d 525, 530-31 (D.C. Cir. 1982). See also *Sierra Club v. Castle*, 657 F.2d 298 (D.C. Cir. 1981).

<sup>45</sup> See *City of New Orleans v. SEC*, 969 F.2d 1163, 1167 (D.C. Cir. 1992).

<sup>46</sup> *Sierra Club*, 657 F.2d at 333.

## **G. ALTHA seeks clarification of some data points and concepts in the proposed methodology**

In analyzing the proposed methodology CMS lays out in this regulation, ALTHA seeks clarification of several concepts. It is our hope that we can get clarification of these issues and resume our analysis of your proposed methodology.

1. The first question that ALTHA seeks information on is how CMS dealt with the wage index adjustment that was phased-in beginning with the first year of the LTACH PPS. In the first year of the PPS only 20 percent of the effect of the wage index adjustment was included in the payment rates. Now the wage index adjustment is fully phased-in. Because the wage index tends to reduce payments to LTACHs, it is important to ascertain that the effect of the partial index adjustment is factored into CMS' proposed BNA calculation. Specifically, when CMS calculated the differential in 2003 between payments under the TEFRA system versus payments under the LTACH system, we suspect CMS used 20 percent as the wage index effect. The resulting differential was 3.75 percent higher payments under the PPS. However, if CMS had adjusted the payment amounts by the fully phased-in wage index adjustment, the agency would have calculated lower payments under the PPS and the 3.75 percent differential would have been less. If CMS were to apply the one-time BNA, the agency should apply that lower differential to the current base rate; otherwise, CMS would be overstating the adjustment needed. From the limited detail provided in the rule, ALTHA cannot determine what wage adjustment level CMS used and we ask for clarification on this point.

2. ALTHA also asks CMS to reconsider its definition of the "first year" of the LTACH PPS. It is possible to define it as the first fiscal year for which the PPS was in effect. Typically when Congress instructs policy changes to be budget neutral the test of that neutrality is not change in outlays during the fiscal year, and CBO would estimate the budget impact from that perspective. Viewing the first year of the LTACH PPS as the first fiscal year has significant impact on the calculation of the one-time BNA. This is primarily because a significant number of LTACH facilities had only a few months under the LTACH PPS during the first fiscal year, but had many more months of PPS payments during their first cost reporting year. Using this approach would yield a lower BNA amount. It would also provide consistency, since CMS plans to implement the adjustment on a fiscal year basis, rather than on a cost reporting year basis for each hospital.

3. ALTHA asks CMS to clarify the basis for using 0.25 percent as the "significant" threshold level for triggering a BNA. ALTHA believes that the 0.25 percent trigger may be too sensitive a threshold level and may trigger an adjustment unnecessarily. ALTHA notes that CMS recently stated that a 0.25 threshold level for forecast error was too sensitive for making corrections to the skilled nursing facility market basket update, and ALTHA would like CMS to explain this somewhat contradictory stance.

**Recommendation:** ALTHA has never and does not now support the concept of a one-time BNA. ALTHA maintains that CMS has met its obligation to transition in a budget-neutral fashion from the TEFRA system to the LTACH PPS. ALTHA believes that the concept of applying an adjustment based on a prior period to the LTACH PPS is anathema to the philosophy of a prospective payment system and that time and time again CMS has agreed with that position. We also believe that CMS has made many

payment changes already that have addressed overpayments in the first year of the PPS and that have reduced payments in each subsequent year; therefore, a one-time BNA would be redundant and punitive. Finally, ALTHA cannot fully respond to CMS' methodology because CMS has not made available data that ALTHA needs to analyze payments in the first year of the PPS. ALTHA has submitted a FOIA request for those data. Once we receive it, ALTHA intends to communicate additional comments after analyzing the data.

**(7) ALTHA disputes RTI's TEP conclusions that LTACH patients cannot be distinguished from patients seen in other settings**

**Issue.** In the regulation, CMS summarizes the meetings of RTI's Technical Expert Panels (TEPs). In FY 2005, CMS awarded RTI a contract to evaluate the feasibility of developing patient and facility level criteria to distinguish LTACH patients from those treated in other settings. RTI has since released two reports describing LTACH patients and comparing them with patients treated in other acute care and PAC settings. On January 30, 2007, RTI convened two TEPs comprised of physicians, nurses, and hospital administrators from LTACHs and other inpatient settings that treat medically complex patients. The first TEP sought to identify a set of clinical indicators that uniquely distinguish LTACHs from other acute care settings. CMS notes that the consensus in that meeting was that LTACHs provide a service comparable to general acute step-down units that is not unique to LTACHs. CMS notes that panel members acknowledged there may need to be more work to measure outcomes for medically complex patients in different settings.

The second TEP convened on November 6, 2007, and focused on Medicare patients with respiratory conditions that required mechanical ventilation. RTI presented analyses of Medicare claims data for patients with episodes of care characterized by vent-related diagnoses during their acute admission. CMS said the analyses demonstrated that between areas that had LTACHs and those that did not, there were few differences in average episode length, Medicare cost, mortality, or length of time before discharge home. In another analysis of patients with a higher probability of using LTACHs versus those with low probability (in areas with LTACHs), CMS states that for high-probability patients mortality was lower and 60-day likelihood of discharge was higher for patients referred to LTACHs than those staying in acute settings. RTI defined high probability of using LTACHs as medically complex ventilator cases with longer prior intensive care unit stays.

**Comment:** ALTHA disputes CMS' description of the results of the TEPs for several reasons.

**A. The composition of the TEPs did not adequately include LTACH experts**

CMS notes that RTI's TEPs were comprised of clinicians and administrators of a cross-section of acute care settings. Providers from settings other than LTACHs dominated the panel. While ALTHA understands the desire to have a broad cross-section of providers, the panel had too few LTACH providers to make the conversation meaningful. ALTHA members who sat on the TEPs note that the other panel members did not have much expertise in the kinds of patients LTACHs treat. CMS' use of that word "consensus" to describe the summation of the group's discussion is incorrect and reflects this lack of understanding of the unique role of LTACHs in treating medically complex patients.

**B. ALTHA is concerned that RTI and the TEPs have not explored evidence demonstrating the unique characteristics of both LTACH patients and services**

CMS notes that clinicians agree that LTACHs specialize in treating critically ill patients with multiple comorbidities and other longer term, acute level needs. However, CMS says the panels did not believe that these patients could be classified as unique from those seen in other settings, with one provider stating, “there is no such thing as an LTCH-only patient.” While other settings may treat patients with similar characteristics to LTACHs, ALTHA member companies know from experience that the care they provide to these patients is distinguishable and their role in their communities is highly valued because of their unique capabilities. Data from one ALTHA member company demonstrates that in 2007, 11 percent of patients traveled more than 50 miles to reach a LTACH. This suggests that the services provided are deemed important enough by the referring provider to justify long transports.

**C. ALTHA eagerly anticipates the opportunity to give the next RTI study a careful review**

CMS notes that RTI has conducted a number of analyses that will likely be included in the Phase III report. ALTHA looks forward to the opportunity to review these studies carefully. ALTHA is encouraged by RTI’s finding that mortality was lower and 60-day likelihood of discharge was higher for ventilator patients referred to LTACHs. ALTHA feels this data point demonstrates the specialized and high-quality care that LTACHs provide to such patients, and anticipates that RTI’s research will find additional examples that support the unique role of LTACHs in the PAC continuum.

**Recommendation.** ALTHA recommends that RTI hold another TEP that has a better balance of LTACH and other acute care or PAC providers. ALTHA disagrees with CMS’ characterization of the TEPs’ findings. ALTHA is concerned that CMS’ conclusions on the RTI TEP results suggest that the agency will not move forward in developing LTACH patient and facility criteria as called for by the MMSEA and urged by MedPAC. ALTHA also anticipates the release of RTI’s Phase III report and requests that CMS and RTI engage with LTACH providers on the findings of the report.

**(8) ALTHA does not believe that the regulatory impact analysis appropriately captures the effects of this proposed rule**

**Issue.** In Table 9 of the proposed rule, CMS projects the impact of the proposed payment rate and policy changes contained in the regulation. The impact analysis is based primarily on CMS’ estimates of changes in payment due to the update to the standard federal rate and assumptions on the increase of payments for certain cost-based outliers.

**Comment.** When computing payments per discharge in rate year 2008, CMS “applied both the revised short-stay outlier (SSO) policy and revised standard federal rate for all of RY 2008.” This is despite the fact that the MMSEA only revised these policies for discharges between April 1, 2008, and June 30, 2008. Application of the revised SSO policy to discharges occurring between July 1, 2007, and March 31, 2008, overstates RY 2008 payments per discharge; therefore, application of the revised standard federal rate understates RY 2008 payments per discharge. This approach overestimates the overall percentage increase in the estimated payment per case for RY 2009.

In Table 9, the estimated impact of the changes to the federal rate and area wage adjustments for all hospitals is 2.1 percent (columns 6 and 7). Column 8 of this table reflects a 2.9 percent increase for all changes. CMS determined that the 0.8 percent difference “is mostly attributable to the effect of the estimated increase in payments for high-cost outlier (HCO) and SSO cases in RY 2009 as compared to RY 2008.” CMS explains that the agency expects this increase because these outlier cases are reimbursed predominantly “based on the estimated cost of the case.” As such, the assumption is that a 3.5 percent market basket increase in cost would result in a corresponding increase in payment for the cost-based outlier cases.

ALTHA believes this assumption is inaccurate, and CMS has not used this reasoning in the past to explain prior rate year changes in estimated payment per case. Payments for high-cost and short-stay outliers that are based on cost use the ratio of cost-to-charges (RCC) in determining actual reimbursement. However, each hospital’s RCC is updated during the CMS fiscal year, and providers routinely raise charges as costs increase. Any analysis that projects payment increases for outliers based solely on expected cost increase is flawed unless it incorporates projected increases in charges and the dynamic and timing of those increases on Medicare and total charges. It is not proper to assume that the ratio of Medicare to total charges will remain consistent because utilization of certain services by Medicare patients is frequently not the same as that of non-Medicare patients.

In addition, it is not proper to ascribe a “regulatory” impact to items that are not part of a CMS proposal. CMS is attempting to assign a regulatory impact to a predicted cost increase, but doing so overstates the impact of the changes proposed in the rule.

**Recommendation.** ALTHA feels that for the purposes of the impact analysis, CMS should base the RY 2008 estimated payment per case on the expected actual payments during that rate year, and should not reflect a full year’s worth of adjustments that were not effective as of the beginning of the rate year. CMS should also revise its impact analysis to eliminate the 0.8 percent increase due to cost-based outliers. If CMS insists on incorporating the impact of the market basket increase on cost-based payments for outlier cases into its estimate, the agency should also account for the increase in charges and the timing of these RCC changes. CMS is also encouraged to publish a more detailed accounting of all regulatory impact projections. The impact tables published with proposed and final rules are relied on by many healthcare entities, and as such CMS should strive to produce the most accurate tables.

**(9) ALTHA asks CMS for relief regarding differential treatment of LTACHs under the 25 percent rule**

**Issue:** The MMSEA halts the implementation of the 25 percent rule for freestanding LTACHs and freezes the percent threshold for co-located LTACHs. However, this statute only applies to LTACHs whose cost reporting periods begin after the date of enactment of the act, December 29, 2007. For LTACHs with cost reporting periods that began on or after July 1, 2007 different admission thresholds will apply than for thresholds specified under the Act.

**Comment:** While CMS does not ask for comments on the 25 percent rule and how the agency will implement the provisions of the MMSEA relating to it in this proposed regulation, ALTHA believes this issue merits comment now. ALTHA members operate

hospitals with cost reporting periods that begin throughout the year, and we expect that some LTACHs will be subject to 25 percent rule thresholds that were put in place prior to the enactment of the MMSEA, while others will not be subject to the 25 percent rule during this year. The need for clarity on this issue is paramount to hospital operators and presents an important question of equal treatment for ALTHA.

ALTHA does not support the implementation of the 25 percent rule, as has been discussed on multiple occasions with the agency, on the basis that it is an inaccurate and unfair means of determining the appropriateness of patient referrals to LTACHs. ALTHA is concerned that, in this case, this rule may be applied to only certain LTACHs with cost reporting periods beginning after July 1, 2007 and before December 29, 2007. ALTHA does not believe Congress intended for the 25 percent rule thresholds effective after July 1, 2007 would affect certain facilities but not others. ALTHA believes that this was an oversight and that the intention of Congress was to protect LTACHs from the punitive patient referral thresholds under the 25 percent rule for the next three years. ALTHA does not believe that there can be any policy rationale for LTACHs to be governed by different payment rules based on their cost report start date. We therefore ask CMS to consider this issue with alacrity so that LTACHs with cost reporting period start dates before December 29, 2007 can understand how CMS intends to reimburse them for treating Medicare beneficiaries.

**Recommendation.** ALTHA recommends that CMS promulgate regulations as soon as possible that implement the provisions in the MMSEA related to the 25 percent rule, and that CMS address this issue of two separate sets of rules that would lead to unequal treatment of LTACHs solely based on their cost reporting period start date. Finally, ALTHA recommends that CMS adopt the 25 percent rule threshold levels that were stated in the MMSEA for all LTACHs for this year, and not choose to treat LTACHs differently solely because of the start date of their cost reporting period.

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In summary, ALTHA supports the finalization of the CMS proposed policy to issue regulations a single time a year and move the LTACH rate year to the federal fiscal year. ALTHA commends CMS for its responsiveness to the request of LTACH providers who requested this change. In addition, ALTHA supports the CMS proposed methodology for calculating a LTACH wage index in areas without a short-term acute care hospital.

ALTHA requests that CMS not finalize its proposal to reduce the market basket update. Instead, CMS should provide for a full market basket update to the RY 2008 standard federal rate in the final rule. LTACHs are currently facing negative margins and are relying on CMS to increase payments to match inflation. As discussed at length above, ALTHA also asks CMS to reconsider its position with regard to the one-time BNA. ALTHA will continue to evaluate the methodology CMS lays out in this proposed regulation, and awaits the release of key data from CMS in order to undertake a complete and thorough evaluation. ALTHA intends to communicate additional comments after analyzing the data. ALTHA recommends CMS not apply the 25 percent rule thresholds for co-located and freestanding LTACHs that applied before the passage of the MMSEA because this would lead to unequal treatment of some LTACHs; ALTHA recommends all LTACHs be subject to the 25 percent rule thresholds as stated in the MMSEA for all of RY 2008. Finally, ALTHA encourages CMS to continue to seek

information about the role of LTACHs in the care continuum and to act quickly and with provider input to begin proposing certification criteria.

Sincerely,

A handwritten signature in black ink that reads "William Walters". The signature is written in a cursive style with a large, sweeping initial "W".

William Walters  
Chief Executive Officer  
Acute Long Term Hospital Association