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Hon. Kerry Weems
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1493-IFC2
200 Independence Avenue, SW
Washington, D.C. 20201

Re: 42 CFR Parts 412 Medicare Program; Changes for Long-Term Care Hospitals Required by Certain Provisions of the Medicare, Medicaid, SCHIP Extension Act of 2007: 3-Year Moratorium on the Establishment of New Long-Term Care Hospitals and Long-Term Care Hospital Satellite Facilities and Increases in Beds in Existing Long-Term Care Hospitals and Long-Term Care Hospital Satellite Facilities; and 3-Year Delay in the Applications of Certain Payment Adjustments

Dear Mr. Weems,

This letter presents the Acute Long Term Hospital Association's (ALTHA) comments and recommendations on the interim final rule implementing certain provisions of section 114 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) relating to long-term acute care hospitals (LTACHs), which the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* on May 22, 2008. 73 Fed. Reg. 29699.

As we discuss more fully below, ALTHA agrees with certain aspects of CMS's implementation of the MMSEA with regard to LTACHs. However, we disagree with many aspects of CMS's interpretation of the MMSEA as too narrow and/or inequitable. ALTHA requests that CMS modify its interpretation of section 114 of the MMSEA, and revise the regulations accordingly, to provide a more equitable and consistent application of changes to the 25% Rule across LTACHs, and to implement the exceptions to the moratorium so as not to deny certification to LTACH projects that were significantly developed prior to the date of enactment and satisfy the general intent of the exceptions.

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 over three hundred LTACH hospitals across the United States, constituting over two-thirds of this provider community nationwide. We appreciate the opportunity to express our concerns with these proposed policies and trust that CMS will carefully consider each of the issues raised in this letter.

PERCENTAGE THRESHOLD PAYMENT ADJUSTMENT TO LTACHS AND LTACH SATELLITE FACILITIES (25% RULE)

(1) ALTHA strongly disagrees with CMS's continued effort to impose the "25% Rule" and other arbitrary payment policies on LTACHs. CMS should instead focus its resources on developing and implementing comprehensive LTACH certification criteria long-suggested by MedPAC and initiated by Congress with the MMSEA.

Issue. Congress passed § 114 of the MMSEA to further define the characteristics of LTACH facilities and the patients LTACHs treat, while staying the application of current CMS payment policies, including the "25% Rule" at 42 C.F.R. §§ 412.534 and 412.536. Specifically, Congress refined the statutory definition of an LTACH, enacted new facility criteria for LTACHs, and required CMS to conduct a study on the establishment of national facility and patient criteria for LTACHs by June 2009. Congress also prohibited CMS from applying the 25% Rule in its current form for three years. The percentage threshold payment adjustment imposed on LTACHs for patients admitted from non-co-located hospitals is suspended. The percentage threshold payment adjustment imposed on LTACHs for patients admitted from co-located hospitals is raised to 50 percent (or 75 percent for rural, metropolitan statistical area (MSA) dominant, and single urban). In so doing, Congress has put into effect what the Medicare Payment Advisory Commission (MedPAC), ALTHA, and other hospital groups have been telling CMS for years: LTACH facility and patient criteria are a better way to ensure proper patient placement in LTACHs than arbitrary payment policies, including the 25% Rule, that do not differentiate between patients based upon their condition or medical needs. Yet the interim final rule reaffirms CMS's intent to impose these payment policies to as many LTACHs as possible by adopting an exceedingly narrow interpretation of the regulatory relief under the MMSEA. In addition, CMS has revised the regulations so that the payment adjustments at § 412.534 and § 412.536 will recommence for cost reporting periods beginning after December 29, 2010.

Comment. ALTHA continues to recommend that CMS reconsider its policy for applying the 25% Rule in light of the MedPAC recommendations in June 2004 that the certification criteria for the Medicare LTACH provider category be strengthened to ensure that LTACH payments are being made to only those providers that are administering medically complex care to severely ill patients. ALTHA supports this approach as a more defined method for limiting LTACH payments to hospitals that are truly caring for a medically complex patient population. Unfortunately, CMS continues to advance policies in this interim final rule that rely on arbitrary and unproven payment reductions that will <u>not</u> achieve the stated policy goals and will significantly hinder the ability of many LTACHs to continue to provide quality patient care to Medicare beneficiaries. Adopting comprehensive LTACH certification criteria is the best approach, if quality of care is to be encouraged, not arbitrary payment reductions.

In § 114(b) of the MMSEA, Congress instructed the Secretary of the Department of Health and Human Services (the Secretary) to conduct a study on the establishment of national LTACH facility and patient criteria for the purpose of determining medical necessity, appropriateness of admissions and continued stay at, and discharge from, LTACHs. The Secretary must submit a report on the results of this study to Congress before June 2009. Both the study and the report are required to consider recommendations on LTACH-specific facility and patient criteria contained in MedPAC's

June 2004 report to Congress. In requiring this study and delaying the continued expansion of the 25% Rule, Congress clearly intended that CMS re-examine its approach to LTACH payment policies and establish criteria, which would replace policies such as the 25% Rule. The way in which CMS is implementing the MMSEA in the interim final rule ignores the intent and purpose of the MMSEA.

Fundamentally, CMS continues to support a payment policy that is not based on publicly-available research of its design and effectiveness. CMS's primary rationale for the 25% Rule is the assumption that LTACHs are functioning as units of short term acute care hospitals (STACHs) such that Medicare is paying "twice" for a single episode of care. Despite repeatedly citing this concern, CMS's own researchers have not found evidence that any LTACHs, let alone freestanding LTACHs are acting as units of STACHs. It is entirely inappropriate for CMS to continue to pursue such a punitive payment policy for LTACHs when researchers have concluded that CMS's purported rationale for the rule is "poorly understood" and not yet supported by data.

Recommendation. First, CMS should immediately make such additional changes to its regulations as are necessary to fully implement § 114(c) of the MMSEA so that no subcategory of LTACHs are unfairly denied relief from the 25% Rule for the three years provided by the Act. Second, CMS should recognize that § 114 of the MMSEA is a clear expression by Congress that CMS is not on the right track when it comes to LTACH payment policy. As MedPAC, ALTHA, and other hospital groups have been telling CMS for many years, the agency needs to work with the LTACH industry to develop new facility and patient certification criteria for LTACHs. The new LTACH definition and facility criteria Congress enacted in the MMSEA show that it can be done. With the development of such criteria, ALTHA recommends that CMS: (i) not impose § 412.536 after the three-year period provided by the MMSEA; and (ii) retire § 412.534 entirely once new LTACH criteria are developed.

(2) In order to prevent unequal treatment of LTACHs whose cost reporting periods begin on or after July 1, 2007 and before December 29, 2007, CMS should make changes to the payment adjustment policies under § 412.536 effective on July 1, 2007 and under § 412.534 effective on October 1, 2007, rather than December 29, 2007.

Issue. As required by the MMSEA, CMS makes certain changes to the payment adjustment policy in the interim final rule. Effective for cost reporting periods beginning on or after December 29, 2007 and before December 29, 2010, CMS delays the extension of the 25 percent threshold payment adjustment to "grandfathered" LTACH hospitals-within-hospitals (HIHs) and freestanding LTACHs. Despite this mandated change to CMS policy, CMS makes no accommodation for grandfathered and freestanding LTACHs with cost reporting periods that began on or after July 1, 2007 but before December 29, 2007. This group of LTACHs, with no other common characteristic, remain subject to the provisions of § 412.534 and § 412.536, as appropriate, until the start of their next cost reporting period.

Likewise, in the interim final rule, CMS increases the patient percentage thresholds from 25 percent to 50 percent for certain LTACH HIH and satellite discharges admitted from a co-located hospital, and from 50 percent to 75 percent for certain LTACH HIHs and satellite discharges at rural HIHs or admitted from a co-located MSA dominant or single urban hospital. The interim final rule does not provide relief for those co-located

LTACHs that, as a result of the timing of the transition period, became subject to the full 25 percent threshold for cost reporting periods beginning on or after October 1, 2007 but before December 29, 2007.

Comment. LTACHs should not be disproportionately impacted by the 25% Rule based solely on the start of their cost reporting periods. The changes to the 25% Rule mandated by the MMSEA are effective for cost reporting periods beginning on or after the date of enactment of the MMSEA. For various reasons, Congress did not pass and the President did not sign the MMSEA into law until December 29, 2007. Because the 25% Rule was developed purely through regulation, CMS can implement the MMSEA changes to this policy more evenly among LTACHs by extending these changes to July 1, 2007 for § 412.536 and to October 1, 2007 for § 412.534.

Because § 412.536 was first effective for cost reporting periods beginning on or after July 1, 2007, grandfathered LTACH HIHs and freestanding LTACHs with cost reporting periods beginning on or after July 1, 2007 but before December 29, 2007 remain subject to the percentage threshold requirements until the start of their next cost reporting year. These particular LTACHs remain subject to year one of the transition for a full cost reporting period (*i.e.*, a percentage threshold equal to the lesser of 75 percent or the percentage of the LTACH's discharges that were admitted from the referring hospital during its cost reporting period beginning on or after July 1, 2004 and before July 1, 2005 ("FY 2005")). In some cases, the applicable percentage is far less than 75 percent, making even year one of the transition a significant financial issue for certain LTACHs.

Under § 412.534, those LTACH HIH and LTACH satellite facilities participating in the transition period that have cost reporting periods beginning on or after October 1, 2007 but before December 29, 2007 are subject to the full effect of the 25% Rule for an entire cost reporting period. The MMSEA sets the percentage threshold at least twice as high for co-located LTACHs for three years. Therefore, there is an unfair application of the 25% Rule to these LTACHs for an additional year.

Unless CMS further amends these regulations accordingly, some LTACHs, LTACH HIHs and LTACH satellite facilities will be disproportionately harmed by the 25% Rule simply because of the date their cost reporting period begins.

It is within CMS's authority, and we believe it is CMS's responsibility, to ensure that the LTACH PPS is applied fairly and polices applied evenly to LTACHs. The payment adjustment policies under § 412.534 and § 412.536 are the result of agency rulemaking and, as such, may be modified by CMS. There is no statutory obligation to impose these significant payment penalties on a small minority of LTACHs, LTACH HIHs and LTACH satellite facilities for an additional year. To the contrary, principles of equity support additional revisions to the regulatory text so that the MMSEA is implemented without causing some LTACHs to suffer disproportionate treatment simply by virtue of their cost reporting period.

Recommendation. ALTHA recommends that CMS *extend* the MMSEA's changes to the payment adjustment policies under § 412.534 effective on October 1, 2007 and under § 412.536 effective on July 1, 2007. The MMSEA changes would remain in effect through LTACH cost reporting periods beginning before December 29, 2010, per the MMSEA.

(3) ALTHA generally agrees with the definition of "freestanding" LTACHs, but encourages CMS to clarify how the definition will be applied.

Issue. The interim final rule establishes a definition for "freestanding" LTACHs, which until now had been a commonly used, but undefined, term. A freestanding LTACH is defined as a hospital that: (1) has a Medicare provider agreement; (2) has an average length of stay of greater than 25 days, (3) does not occupy space in a building used by another hospital; (4) does not occupy space in one or more separate or entire buildings located on the same campus as buildings used by another hospital; and (5) is not part of a hospital that provides inpatient services in a building also used by another hospital.

Comment. ALTHA agrees with the definition of freestanding provided that the definition is only intended to distinguish this type of LTACH from LTACHs that are co-located with another inpatient hospital. We are concerned that CMS did not take this opportunity to further clarify the differences between freestanding LTACHs and both HIHs and satellite facilities in order to deny more LTACHs relief from the 25% Rule granted under the MMSEA. If an LTACH is not co-located in a building or on the same campus where another hospital provides inpatient services, then CMS should consider that location as freestanding. That is, the purpose of the definition must be to identity LTACHs that do not obtain admissions directly from a co-located hospital. The FIs/MACs and ROs should use this new definition in this manner, and not to classify additional LTACHs as HIHs and satellite facilities.

Recommendation. CMS should clarify that the phrase "used by another hospital" in the definition of "freestanding" only refers to inpatient uses. This would provide for a consistent application of this definition to LTACHs in the most commonly understood manner.

(4) ALTHA strongly disagrees with CMS's interpretation that the MMSEA prohibits the application of the payment adjustment policies under § 412.536 to only certain LTACHs and increases the percentage threshold under § 412.534 to only certain LTACH HIHs and LTACH satellite facilities.

Issue. Effective for hospital cost reporting periods beginning on or after October 1, 2004, subject to certain exceptions, § 412.534 provides for lower rates of reimbursement to HIHs and LTACH satellite facilities for those Medicare patients admitted from their host hospitals that are in excess of a specified percentage threshold. For HIHs and LTACH satellite facilities opened after October 1, 2004, the Medicare admissions threshold has been established at 25 percent except for LTACHs located in rural hospitals, and LTACHs co-located with single urban hospitals and MSA dominant hospitals where the percentage is no more than 50 percent, nor less than 25 percent. In the rate year 2008 LTACH PPS final rule, CMS established, at § 412.536, an adjustment that applies to all LTACHs based on the percentage of Medicare discharges that had been admitted to a LTACH or LTACH satellite facility from an individual referring hospital with which the LTACH or LTACH satellite is not co-located.

The MMSEA precludes the Secretary from implementing, during a three-year period, the provisions added by the May 2007 final rule that extended the 25% Rule to patients admitted to LTACHs from non-co-located hospitals. The MMSEA also modifies, during the same three-year period, the effect of the 25% Rule for LTACHs that are co-located with other hospitals. For HIHs and satellite facilities, the applicable percentage threshold

is set at 50 percent and not phased in to the 25 percent level. For HIHs and satellite facilities located in rural areas and those co-located with MSA dominant hospitals or single urban hospitals, the percentage threshold is set at no more than 75 percent.

In the interim final rule, CMS interprets the MMSEA as not extending relief under § 412.534 to (1) nongrandfathered HIHs not subject to transition, (2) grandfathered LTACH satellite facilities, and (3) nongrandfathered LTACH satellite facilities not subject to transition; and not extending relief under § 412.536 to (1) all nongrandfathered HIHs, (2) grandfathered LTACH satellite facilities, and (3) all nongrandfathered LTACH satellite facilities.

Comment. CMS misinterprets the statute and fails to appreciate the legislative intent. The MMSEA is intended to provide LTACHs relief from the 25% Rule for a three-year period while CMS conducts a study on the establishment of national patient and facility criteria for LTACH services with the purpose of determining medical necessity, appropriateness of admission, and continued stay at, and discharge from, LTACHs. The MMSEA did not exclude subcategories of LTACHs from the three-year relief from the 25% Rule.

The application of § 412.534 and § 412.536 as indicated in the interim final rule will result in unfair and inequitable treatment among LTACHs. First, grandfathered LTACHs have historically been treated as exempt from certain policies that were adopted at a later date (*e.g.*, the separateness criteria of 42 C.F.R. § 412.22(e)). Under the interim final rule, grandfathered LTACHs are subject to more onerous payment policies of the 25% Rule than many other LTACHs. Second, the continued application of the 25% Rule to some nongrandfathered LTACHs and LTACH satellite facilities and not to other types of LTACHs has no basis in public policy. In the interim final rule, CMS goes to great lengths to parse the words of the MMSEA before taking the narrowest approach conceivable to limiting the payment adjustment policies of § 412.534 and § 412.536 to certain subcategories of LTACHs, LTACH HIHs and LTACH satellite facilities. This is a harmful approach to establishing public policy that, if left unchanged, will unfairly harm some LTACHs contrary to the intent of the MMSEA.

In reference to the adoption of a definition for "freestanding," CMS declares its intent to "minimize confusion and ensure the MMSEA is implemented consistently."[1] The agency's intent to provide clear guidance is not incorporated in CMS's approach to § 412.534 and § 412.536. In no way does CMS's application of the 25% Rule minimize confusion or implement consistency. In fact, the opposite is true. The interim final rule's application of the 25% Rule is more confusing and more inconsistent. In order to explain its approach, CMS found it necessary to include two separate tables describing the many ways the same piece of legislation purportedly applies to a growing number of subcategories of LTACHs. Considering that the LTACH industry is relatively small compared to other Medicare provider types, this differentiation among LTACHs raises obvious concerns of unfair treatment. Hospital administrators and management are now left with the difficult task of determining which of the many applications of § 412.534 and § 412.536 apply to individual campuses and patients during any particular cost reporting period – a task that is increasingly complex for multi-campus LTACHs.

CMS created the 25% Rule through the rulemaking process and CMS has the authority to amend the regulations in order to apply the intent of the Congress and ensure equal

[1] See 73 Fed. Reg. 29702 (May 22, 2008).

treatment among LTACHs. Accordingly, CMS should apply the MMSEA provisions consistently across LTACHs for at least the three years required by the MMSEA.

Recommendation. ALTHA recommends that CMS not apply § 412.536 to <u>any</u> LTACH, including LTACH HIHs and LTACH satellite facilities, during the cost reporting periods beginning on or after October 1, 2007 and for the three years provided by the MMSEA. Similarly, ALTHA recommends that CMS establish the percentage threshold under § 412.534 at 50 percent for <u>all</u> LTACH HIHs and LTACH satellite facilities, except for LTACHs located in rural areas, and co-located with MSA dominant hospitals or single urban hospitals where the percentage is no more than 75 percent.

(5) <u>The interim final rule fails to acknowledge that MMSEA provides a percentage threshold of 75% for LTACH HIHs and satellite facilities co-located with an MSA-dominant hospital. The 75% threshold applies equally to HIHs and satellite facilities located in rural areas and those which receive referrals from MSA dominant hospitals or single urban hospitals</u>.

Issue. Section 412.534 generally establishes a payment adjustment threshold of 25 percent for all Medicare inpatients admitted from a co-located hospital, except for HIHs and satellite facilities located in rural areas and HIHs and satellite facilities co-located with MSA-dominant hospitals or single urban hospitals where the percentage is no more than 50 percent, nor less than 25 percent. Pursuant to § 412.534(e)(2) prior to the MMSEA, HIHs and satellite facilities co-located with MSA-dominant hospitals are subject to a percentage threshold that is equal to the percentage of total Medicare discharges in the MSA in which the hospital is located that are from the co-located hospital for the cost reporting period for which the adjustment was made, but in no case less than 25 percent or more than 50 percent.

Effective for cost reporting periods beginning on or after December 29, 2007 and before December 29, 2010, the MMSEA increases the patient percentage thresholds from 25 percent to 50 percent, to simply "up to 75%" for LTACH HIHs and LTACH satellite facilities co-located with an MSA-dominant hospital. The MMSEA does *not* differentiate between HIHs located in rural areas and HIHs co-located with MSA-dominant hospitals or single urban hospitals. All three special cases are treated the same under the MMSEA. In the interim final rule, CMS failed to appropriately revise the regulatory text so that the percentage threshold is simply 75 percent for these special cases. The adjustment should no longer be based on the percentage of total Medicare discharges in the MSA in which the hospital is located that are from the co-located hospital.

Comment. CMS misinterprets the effect of the MMSEA's changes on LTACH HIHs and LTACH satellite facilities co-located with an MSA-dominant hospital. The statutory language clearly limits the application of § 412.534 to discharges exceeding 75 percent. There is no adjustment based on the percentage of total Medicare discharges originating from the host MSA-dominant hospital. The applicable portion of the MMSEA provides as follows:

> Payment to an applicable long-term care hospital or satellite facility which is located in a rural area or which is co-located with an urban single or MSA dominant hospital under paragraphs (d)(1), (e)(1), and (e)(4) of section 412.534 of title 42, Code of Federal Regulations, shall not be subject to any payment adjustment under such section ***if no more than***

75 percent of the hospital's Medicare discharges… are admitted from a co-located hospital.

The changes to § 412.534 adopted in the interim final rule do not implement the full extent of the relief from the 25% Rule mandated by the MMSEA. The interim final rule provides that "[p]ayments for long-term care hospitals and long-term care hospital satellite facilities subject to [the transition period] are determined using the methodology specified in paragraph (e)(1) of this section except that 75 percent is substituted for 50 percent.[2] This is an incomplete change to the regulatory text. The MMSEA does not substitute 75 percent for 50 percent. Instead, the MMSEA limited CMS to applying a payment adjustment to only those discharges in excess of 75 percent.

Recommendation. ALTHA recommends that CMS issue a technical correction to § 412.534 acknowledging that LTACH HIHs and LTACH satellite facilities co-located with an MSA-dominant hospital are subject to a percentage threshold of 75 percent for cost reporting periods beginning on or after December 29, 2007 and before December 29, 2010.

MORATORIUM ON THE ESTABLISHMENT OF NEW LTACHS, NEW LTACH SATELLITE FACILITIES, AND NEW LTACH BEDS WITH EXCEPTIONS

(1) ALTHA agrees that MMSEA provides three exceptions for new LTACHs and LTACH satellites, and one exception for new LTACH beds, and that those two categories of exceptions are mutually exclusive.

Issue. MMSEA establishes a three-year moratorium on new LTACHs, LTACH satellites, and LTACH beds established after December 29, 2007. Section 114(d)(2) of MMSEA creates three exceptions pursuant to which an entity or hospital may by enrolled and classified as an LTACH despite the moratorium. The three exceptions in section 114(d)(2) do not apply to the moratorium on an increase in beds at section 114(d)(1)(B) of MMSEA. Section 114(d)(3) of MMSEA creates one exception pursuant to which an existing LTACH or LTACH satellite facility may increase the number of its beds. The exception at section 114(d)(3)(A) of MMSEA only applies to the moratorium on increases in beds at existing LTACHs or LTACH satellites facilities, and not to the moratorium on the establishment of LTACHs and LTACH satellite facilities.

Comment. ALTHA agrees with CMS that the two categories of exceptions to the moratorium are mutually exclusive.

(2) ALTHA agrees that the phrase "qualifying period" means the period during which an existing hospital collects length of stay data to qualify as an LTACH.

Issue. The MMSEA provides an exception for new LTACHs that, on or before December 29, 2007, began the "qualifying period" for payment under the LTACH PPS. In the preamble to the interim final rule, CMS points out that it is technically impossible for a

[2] 73 Fed. Reg. 29710 (May 22, 2008).

LTACH to begin a qualifying period since a hospital is not technically enrolled and classified as an LTACH until after successfully completing the qualifying period.

Comment. ALTHA agrees with CMS's interpretation of "qualifying period" as relating to the period during which an existing hospital collects length of stay data to qualify as an LTACH. This interpretation of the MMSEA is illustrative of the common sense approach CMS has taken to interpret certain provisions of MMSEA. It is inconsistent for CMS to adopt an excessively strict interpretation of other provisions, such as the 25% Rule modifications discussed above, when common sense necessitates otherwise.

(3) ALTHA disagrees with CMS's interpretation that LTACH satellite facilities cannot qualify for the first exception to the moratorium as a result of beginning its qualifying period for payment under LTACH PPS on or before December 29, 2007.

Issue. MMSEA's first exception for new LTACHs and LTACH satellite facilities provides that the moratorium shall not apply to an LTACH that, as of December 29, 2007, "began its qualifying period for payment as a long-term care hospital under section 412.23(e) of title 42, Code of Federal Regulations, on or before the date of the enactment of this Act." CMS states that this exception is not applicable to LTACH satellite facilities because "there is no 'qualifying period' for the establishment of a satellite facility for payment as a [LTACH] under § 412.23(e)."

Comment. LTACH satellite facilities are subject to the "qualifying period" of the main campus of the LTACH, but are not required to conduct a separate qualifying period. The fact that the main campus meets this exception should suffice if the satellite can otherwise demonstrate that it was under development prior to December 29, 2007. The MMSEA contemplates exception to the moratorium for both qualifying LTACHs and qualifying satellites. Barring satellite facilities from using this exception to the moratorium is inconsistent with statements by CMS elsewhere in the interim final rule. CMS otherwise contends that "it is appropriate to apply paragraph (2) to new LTACH satellite facilities just as it applies to LTACHs" (emphasis added).[3] Later in the preamble to the interim final rule, CMS acknowledges that it is "[o]ur presumption that new LTACH satellite facilities are included in the exceptions in section 114(d)(2) of MMSEA."[4]

Recommendation. ALTHA recommends that CMS permit LTACH satellite facilities to qualify for this exception to the moratorium as a result of the main campus having started its qualifying period prior to December 29, 2007 if the satellite can demonstrate that it was under development prior to that date.

(4) ALTHA disagrees with CMS that the phrase "cost of the project" is limited to the enumerated activities of construction, renovation, lease, or demolition. The term "project" refers generally to the development of a long-term care hospital.

[3] 73 Fed. Reg. 29705 (May 22, 2008).
[4] Id. at 29706.

Issue. The three-year moratorium on the establishment and classification of LTACHs and LTACH satellite facilities does not apply to any LTACH that "has a binding written agreement with an outside, unrelated party for the actual construction, renovation, lease, or demolition for a long-term care hospital and has expended, before [December 29, 2007], at least 10 percent of the estimated cost of the project (or, if less, $2,500,000)." CMS interprets the phrase "cost of the project" to mean only costs related to construction, renovation, lease or demolition.

Comment. CMS misinterprets the meaning of the phrase "cost of the project." Congress did not require funds to be expended only on construction, renovation, lease or demolition. There are many other types of expenditures that could meet the expenditure requirement, including, for example, land purchases and feasibility studies as part of the capitalized project. To qualify for this exception, the hospital should be required to have spent the greater of 10 percent or $2.5M of the *total* project cost for the LTACH facility. Congress created two separate requirements in order to qualify for this exception to the moratorium. The interpretation CMS adopts creates one test, which will exclude new LTACHs that can meet each requirement individually. Under the rule adopted by CMS, a new facility may have a binding contract and substantial expenditures, yet be unable to qualify for enrollment and classification as an LTACH. This approach will cause substantial harm to new facilities that have already expended 10 percent or $2.5M on development costs that may differ from CMS's rigid view of applicable cost categories.

Recommendation. ALTHA recommends that CMS revise its interpretation so that the requirement that 10 percent or $2.5M be expended before December 29, 2007 applies to the *total* project cost for the hospital facility that is being developed to become an LTACH.

(5) <u>ALTHA disagrees with CMS's interpretation of "has expended" to mean "have actually transferred funds</u>."

Issue. The MMSEA permits the enrollment and classification of an LTACH that, as of December 29, 2007, has a binding written agreement with an outside unrelated party for the actual construction, renovation, lease, or demolition for converting the hospital to a LTACH and has expended, before December 29, 2007, at least 10 percent of the estimated cost of the project (or, if less, $2,500,000). CMS interprets the phrase "has expended" to require that the hospital or entity has actually transferred funds as payment for the project as opposed to merely obligating capital and posting the cost of the project on its books as of December 29, 2007. In the preamble, CMS argues that the phrase only has meaning if the funds are actually transferred. According to CMS, the ability to post the expense on the hospital's or entity's ledger could be satisfied by entering into a written agreement. CMS's interpretation appears to conflict with Generally Accepted Accounting Principles (GAAP) and imposes a more strenuous standard than intended by the MMSEA.

Comment. ALTHA disagrees with CMS's overly rigorous interpretation. Entities need not transfer the funds in order to meet the legislative intent that the funds be committed to the project prior to December 29, 2007. CMS should instruct its FIs/MACs and ROs to use GAAP understanding of "expended." Financial Accounting Standard Board (FASB) Statement Number 67, entitled "Accounting for Costs and Initial Rental Operations of Real Estate Projects," establishes accounting and reporting standards for

acquisition, development, construction, selling, and rental costs associated with real estate projects. Specifically, section 4 requires that:

> Payments to obtain an option to acquire real property shall be capitalized as incurred. All other costs related to a property that are incurred before the enterprise acquires the property, or before the enterprise obtains an option to acquire it, shall be capitalized if all of the following conditions are met and otherwise shall be charged to expense as incurred: (a) the costs are directly identifiable with the specific property; (b) the costs would be capitalized if the property were already acquired; and (c) acquisition of the property or of an option to acquire the property is probable."

LTACHs adhere to GAAP for accounting purposes. Since the expenditure of funds is an accounting function, any determination of whether funds have been expended should be in reference to GAAP. The interpretation proposed by CMS in the preamble to the interim final rule will leave a hospital or entity in the precarious situation of having entered into a binding written agreement for the development of a LTACH and committed sufficient funds that is, under CMS's interpretation, prohibited from being enrolled and classified as an LTACH. Enforcing the requirement that the hospital or entity have a binding written agreement and that the funds be appropriately committed for expenditure pursuant to GAAP still gives real meaning to the requirements of the exception.

Recommendation. ALTHA encourages CMS to instruct its FIs/MACs and ROs to interpret the term "expended" in this exception to the moratorium in accordance with GAAP.

(6) <u>ALTHA agrees that the exception to the moratorium for approved certificates of need requires evidence that the entity holding the certificate of need was developing an LTACH before December 29, 2007</u>.

Issue. Section 114(d)(2)(C) of MMSEA provides an exception for a new LTACH that, as of December 29, 2007, ''has obtained an approved certificate of need in a State where one is required on or before the date of the enactment of this Act.'' As CMS noted in the preamble discussion to the interim final rule, many states issue certificates of need (CONs) that grant the holder the right to develop any type of acute care hospital and are not specifically limited to LTACHs.

Comment. ALTHA agrees that simply having an approved CON for a hospital should not qualify for this exception since that would allow any hospital with a CON to convert to an LTACH. However, the FIs/MACs and ROs should consider circumstances where the entity has received an approved CON for a hospital and other evidence exists that the entity was developing an LTACH prior to December 29, 2007. For example, some CON states do not have a separate category of CON for LTACHs in the same way that many states do not have a separate licensure category for LTACHs. The CON may use the more general term "hospital." Significantly, the MMSEA uses the term "long-term care hospital" in the other two exceptions, but this exception does not. This distinction recognizes that an entity may qualify for this exception even if the CON is not specifically limited on its face to developing an LTACH.

Recommendation. ALTHA recommends that CMS accept a CON as approved and obtained if the date of state approval is on or before December 29, 2007. CMS should

only look to the state for that determination when the LTACH is unable to produce a document verifying that information. In addition, if the CON does not specify an LTACH project, the FI/MAC and RO should consider other evidence that the entity was developing an LTACH before December 29, 2007.

(7) ALTHA agrees with CMS's interpretation that MMSEA's prohibition on the enrollment and certification of LTACH beds applies only to Medicare-certified beds at a hospital as of December 29, 2007.

Issue. MMSEA requires the Secretary to impose a moratorium on the establishment of new Medicare-certified beds in existing LTACH or satellite facilities for a three-year period beginning on December 29, 2008.

Comment. ALTHA agrees with CMS that the moratorium applies to Medicare-certified beds beginning on December 29, 2008. The licensure of new beds is not impacted by the MMSEA and remains a state function that the MMSEA did not intend to limit.

(8) CMS should authorize its FIs/MACs and ROs to consider other LTACH projects that may not fit perfectly within one of the enumerated exceptions but meet the intent of the moratorium.

Issue. Congress passed § 114(d)(a) of the MMSEA with the intent of temporarily stopping the addition of new LTACH facilities and beds into the LTACH PPS reimbursement system after December 29, 2007 and three years thereafter. Congress also recognized exceptions to this moratorium so as not to cause undue harm to LTACHs, hospitals and other entities in the process of developing new facilities on or before December 29, 2007. In order to distinguish those projects legitimately under development on December 29, 2007, Congress created a framework for the exceptions, which CMS should seek to apply in a reasonable manner based on common sense and fairness.

Comment. CMS should approve for enrollment and certification those LTACH projects that do not fit perfectly within an exception to the moratorium but meet the legislative intent of the exceptions, which is to permit the certification of new LTACHs that were sufficiently developed when the MMSEA was enacted. FIs/MACs and the ROs should review LTACH projects under development with significant investment as of December 29, 2007 for how close the project comes to meeting an exception, how few LTACH beds will be added to the payment system if the hospital is granted LTACH status, the relative difficulty for patients to obtain LTACH services in the community, and any other factors weighing in favor of certification.

Recommendation. ALTHA encourages CMS to instruct the FIs/MACs and ROs to consider projects for LTACH certification even if they do not fit perfectly within an exception to the moratorium but otherwise meet the legislative intent of the exceptions.

(9) ALTHA encourages CMS to require its FIs/MACs and ROs to review requests for exception under sections 114(d)(2) and (3) on a timely basis.

Issue. CMS indicates in the preamble to the rule that an applicant's FIs/MACs and ROs are charged with making decisions regarding whether a particular situation meets the requirements for an exception to the moratorium on a case-by-case basis.

Comment. Given the complexity of MMSEA and the LTACH PPS regulations, ALTHA agrees that FIs/MACs and ROs are the proper authorities to review the facts of any individual project to establish a new LTACH, LTACH satellite facility or new beds in an existing LTACH or LTACH satellite facility. LTACHs, hospitals and other entities that seek acknowledgement from CMS of an exception to the moratorium have already expended significant funds and time in planning and developing a new LTACH or LTACH satellite facility. Any delay in making a determination will result in further costs and frustration. These hospitals and the communities they serve will necessarily want to know that the intended use of the facility or space will be realized.

Recommendation. We suggest that CMS impose a requirement on its FIs/MACs and ROs to observe a 30-day review period after the applicant has met all criteria for one of the exceptions.

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In summary, ALTHA requests that CMS modify its interpretation of section 114 of the MMSEA, and revise the regulations accordingly, to provide a more equitable and consistent application of changes to the 25% Rule across LTACHs, and to implement the exceptions to the moratorium so as not to deny certification to LTACH projects that were significantly developed prior to the date of enactment and satisfy the general intent of the exceptions.

Sincerely,

William Walters
Chief Executive Officer
Acute Long Term Hospital Association