Submitter : Ms. Linda Long **Date & Time:** 02/10/2004 04:02:53

Organization : do not have one

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Hi,, i'm 51, disabled and on Medicare. I'm very sick: ruptured c5,6 disc's in neck, degenerative disc disease, carpal tunnel, extensive blood clot in right leg from knee to groin. my monthly check is $936. People say that is enough but it is not. I have to buy so many medicines and sometimes go to the doctor twice weekly to get pt for blood clot. I've got a case worker and she told me that i have a spend down of $589. I only got that once when hospitalized. i draw to much for food stamps. i live with my mom and she is like me; many medications. her check ss $700 va $183. that might seem like a lot of money to case workers but it's not. they will not consider car expences or just living expences. If you know of someone that might just give us a gift card for groceries for maybe just a month would even help. I've had to buy one tube of an antibiotic cream for my blood clot leg (because of skin ulcers), and now the doc has given me another prescription for it. but i can't buy it. do you know of someone that might consider helping us? thank you

linda long
506 N. Selvidge St.
Dalton, Ga 30720-3129
amedeus5@hotmail.com

Submitter : Ms. Sandra Dzurek **Date & Time:** 03/01/2004 06:03:46

Organization : Plymouth House Health Care

Category : Long-term Care

Issue Areas/Comments

GENERAL

GENERAL

Agree with proposed action

Sections

Average Length of Stay Calculation

21 days

Submitter : Mrs. LaDonna Harbour **Date & Time:** 03/02/2004 04:03:48

Organization : Perry Memorial Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

I would like to comment on the nursing staffing documentation. Will this affect hospitals with swingbeds and if so this could be rather confusing as well as burdensome since the nursing staff also care for the acute patients. How would you differentiate nursing staff? While I understand the concern for nurse-patient ratio it is also necessary to consider the amount of time this will take for monitoring and documentation purposes.

Submitter : **Date & Time:** 03/02/2004 09:03:53

Organization :

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I'd like to know the difference between the number of 'new' regulations and the number of 'deleted' or 'terminated' regulations under this new CMS which I, the taxpayer, am funding. Are we getting more streamlined or simply adding to the already absurdly high number of 'regulations.'

Submitter : Ms. Cynthia Cieciwa **Date & Time:** 03/03/2004 08:03:14

Organization : Trinity Continuing Care Services

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

Daily staff is currently posted in each facility with a breakdown by shift. Public benefit does not warrant this staff time committment. This is redundant, bureaucratic, and absolutely unnecessary. This hinders the care of the elders that you are attempting to protect. This in no way is correlated with quality of care as staffing levels are already monitored with minimums in place

Submitter : Ms. Mary Vasseur **Date & Time:** 03/08/2004 04:03:22

Organization : Purchase Cancer Group

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

The cuts in medicare are hurting our patients, some are having to go to the hospital for treatments, and the waiting for a bed at times are 2-3 days. Patients can not always receive the drug they were using because it is not covered. Our Doctors have the patients best interest at hear.

Sections

Average Length of Stay Calculation

The cut in Medicare is hurting our Oncology patients. Some of our patients are having to go the hospital to receive their treatment and this is not in a timely matter, sometimes they wait days for a day. Our Doctors have the best interest in the patient and the cuts are not helping our patient or our Doctors regarding the time of treatment the patients can now receive.

Submitter : Mrs. Sandra Dickerson **Date & Time:** 03/08/2004 04:03:11

Organization : Purchase Cancer Group, PSC

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

The medicare cuts for the cancer patients is hurtint the patients.They cannot receive some of the drugs they need in the office. They are going to the hospital and are not always receiving their treatments on the day they are supposed to have them. Our doctors are caring, compassionate people. They care deeply for their patients and want them to have the best of care.This will not happen if the cuts are deeper. Cancer touches thousands of people each day.
All of us wants our loved ones to receive the best care possible.
Please consider the lives of thousands of people when making these cuts.

CMS-1263-P-8
Submitter : Ms. Sherry Farrer Date & Time:
Organization :
Category :
03/09/2004 06:03:59
Medical Consultants
Nurse
Issue Areas/Comments
GENERAL
GENERAL
After practicing in oncology for 13 plus years as an RN and as a manager I have always felt the amount of time we spend teaching and preparing our
patients and families to receive their chemotherapy should be billiable. My practice is an outpatient facility we average 30-40 new patients a month.
The time the RNs spend in teaching a new patient is at least one hour. In addition too new patients there are times that new drugs are added or the
patient is changed to a different regimen. Again requiring more teaching. So there would need to be two levels of teaching.

Also there are supplies that we use that we are not reimbursed for. If the patient has a central line we use a special needle and Central Line Dressing
kit. Also the IV needles and IV start kits are not reimbursed. I am sure there may be other supplies for consideration but this is just some
examples. I appreciate this opportunity to share this information with you.

CMS-1263-P-9
Submitter : Date & Time:
Organization :
Category :
03/09/2004 08:03:33
Individual
Issue Areas/Comments
GENERAL
GENERAL
I

This is all that was received on this comment. No other information came through.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow “Attach File” button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

CMS-1263-P-10
Submitter : Ms. Parry Pierce Date & Time:
Organization :
Category :
03/11/2004 05:03:13
Pierce Professionals
Nurse
Issue Areas/Comments
GENERAL
GENERAL
I am amazed that there is no law or regulation already to require Long Term Care Facilities to report their staffing levels of licensed personnel; or
perhaps there is such a regulation which I am not aware of? This seems to be a very important aspect of care that should be monitored closely if we
value the care and safety of our elderly population. They are ignored much too often; and so are the needs of nursing staff. We need more nurses
and we need more government funded support of nursing education to alleviate the critical nursing shortage in this country. Thank you, P.W
Pierce, RN

CMS-1263-P-11
Submitter : Ms. Sandra Haskins Date & Time:
Organization :
Category :
03/17/2004 06:03:56
Country Drive Care Center
Other Health Care Professional
Issue Areas/Comments
GENERAL
GENERAL
Included in this proposal (CMS-3121-P) is the requirement "that SNFs and NFs complete a CMS-specified form at the end of each daily shift to
post the full-time equivalents of registered nurses, licensed practical nurses, licensed vocational nurses and certified nurse assistants who are
directly responsible for resident care, as well as daily resident census information. Facilities would also be required to make this information
available to the public upon request."

In California we already post this information daily: However the reporting either online or by mail to CMS is onerous! Facility staff are already
stretched to the limit by paperwork compliance issues that take away from direct care to our residents.... Although it is felt that this requirement
will only take a few minutes a day - although possible, it is not my experience that any paperwork, we are required to do, takes "just a few
minutes". Regardless, time is a valuable commodity that our residents don't get enough of! Please do NOT take away any more time from
resident care by adding the burden of additional paperwork compliance.....please let us just take care of our residents!

Thank you, Sandra Haskins

CMS-1263-P-12
Submitter : Mrs. barbara smith Date & Time:
Organization :
Category :
03/17/2004 08:03:54
Self
Nurse
Issue Areas/Comments
GENERAL
GENERAL
The only way that the quality of LTC will improve is for the government to ensure that staffing is appropriate to the level of acuity. Having one
nurse and two CNA's when caring for 30 residents who require skilled care may not be enough...the MDS could be utilized for establishing this
acuity classification.

CMS-1263-P-13
Submitter : Ms. Dotti Outland Date & Time:
Organization :
Category :
03/23/2004 12:03:00
UnitedHealth Group
Individual
Issue Areas/Comments
GENERAL
GENERAL
Please see the attached comment letter regarding the proposed long-term care hospital PPS payment update rule.
CMS-1263-P-13-Attach-1.doc

March 23, 2004
Centers for Medicare and Medicaid Services
Attention: CMS-1263-P

Re: Proposed Rule – Prospective Payment System for Long-Term Care Hospitals: Proposed Annual Payment Rate Updates and Policy Changes
Dear Sir or Madam:
Through United HealthCare Insurance Company, UnitedHealth Group ("United") provides Medicare supplement insurance to over 2.5 million Americans. On behalf of UnitedHealth Group, I am submitting this comment regarding the above-referenced proposed rule for payment rate updates and policy changes under the long-term care hospital prospective payment system (LTCH PPS) that appeared in the Federal Register on January 30, 2004.
United's comment concerns Section I.D of the preamble to the proposed rule, entitled "Limitation on Charges to Beneficiaries," on page 4757. Specifically, we wish to comment on the following statements in the preamble, which repeat statements from the June 6, 2003 LTCH PPS payment update rule:
"The discussion in the August 30, 2002, final rule [Prospective Payment System for Long-Term Care Hospitals: Implementation and FY 2003 Rates, 67 FR at 55974-5] was not meant to establish rates or payments for, or define, Medicare-eligible expenses. While we regulate beneficiary liability for coinsurance and deductibles for hospital stays that are covered by Medicare, payments from Medigap insurers to providers for inpatient hospital coverage after Medicare benefits are exhausted are not regulated by us."

On December 4, 1998, CMS (then known as HCFA) published a notice in the Federal Register, "recogniz[ing] that the Model Regulation adopted by the National Association of Insurance Commissioners (NAIC) on April 29, 1998, as corrected and clarified by HCFA, is considered to be the applicable NAIC Model Regulation for purposes of section 1882 of the Social Security Act." (63 Federal Register at 67078.) Section 1882 of the Social Security Act (42 U.S.C. Section 1395ss) provides for recognition of the NAIC Model Regulation as the federal minimum standard for Medicare supplement insurance.

The minimum standard (core) benefits for all plans include, "[u]pon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization…." "Medicare eligible expenses" are defined in the NAIC Model Regulation to mean "expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare." CMS is the federal agency with primary responsibility for the Medicare program. Thus, CMS' discussion of "Medicare eligible expenses" in the preamble to the August 30, 2002 LTCH PPS final rule (67 FR at 55974-5) was appropriate, as was the explanation of how "Medicare eligible expenses" are calculated in CMS' April 2003 Program Memorandum in the "Medigap Bulletin" series (transmittal number 03-01, http://www.cms.hhs.gov/medigap/mdgp0301.pdf).

We believe that the statements quoted above from the preambles to the proposed rule and the June 6,

2003 final rule might give the misleading impression that CMS has somehow repudiated the prior interpretations published in the August 30, 2002 final rule and the April 2003 Program Memorandum. Because CMS has already spoken on the issue, and the purpose of the proposed rule is simply to update LTCH PPS payment levels, we question the need for any further Medigap-related discussion in this context. If the preamble to the final version of the update rule does contain any Medigap-related discussion, it should be solely for the purpose of eliminating confusion by reaffirming the agency's position as expressed in the August 30, 2002 Final Rule and the April 2003 Program Memorandum.

If you have questions or need any additional information, please contact me at the telephone number or e-mail address below.
Sincerely,
Dotti Outland
Director, Government Relations
Ovations Insurance Solutions
Phone: (215) 653-5202 E-mail: doutland@uhc.com
Cc: Kathryn McCann
? Page 2 August 17, 2005

CMS-1263-P-14
Submitter : Mrs. Alison Carlson Date & Time:
Organization :
Category :
03/19/2004 06:03:41
University of Connecticut School of Nursing
Nurse
Issue Areas/Comments
GENERAL
GENERAL
I would like to comment on the proposed mandate to have SNFs list FTE equivalent nurse staffing levels in their facility for each shift. I think
this is a very important piece of information for CMS to have. As a major payor for nursing home care, they are entitled to know just what level
of nursing care they are purchasing. As an RN with over 10 years of experience in LTC, I am ashamed that many of these places are allowed to be
called "NURSING HOMES" when there is so little professional nursing actually occuring because of the limited amount of RN FTEs on the
payroll. Further, I think that only those hours that are provided by RNs providing direct patient care should be allowed to count towards this
calculation. Administrative RNs who do not provide any hands on care should not be counted because they are NOT INVOLVED IN PROVIDING
CARE. Their contribution to the final product - quality of care for the Nursing Home residents - should be considered as a function of some other
calculation. I've worked for administrative nursing supervisors who have told me that they are no longer qualified to provide patient care because it
has been so long since they functioned in a clinical capacity that they would be a danger to patients. The government needs to acknowledge that
the level of compentent professional clinical nurses in LTC is SIMPLY INADEQUATE -as has been reported by various independent agencies who
have examined this issue previously - (IOM). It is an outrage that our nation's elderly, who are responsible for creating and maintaining the
infrastructure that every American enjoys so non-chalantly today, should have to suffer the daily indignities and shoddy quality of care that I have
been a witness to each and every day that I have worked in the LTC industry. I urge the government to take a firm stand on this issue NOW!!!
Don't wait until you or loved one ends up in long-term care bed to find out just how REALLY COMPROMISED the level of care in the average
SNF is on a day-to-day basis.

Submitter : Mrs. Paula Bussard **Date & Time:** 03/22/2004 08:03:24

Organization : Hospital and Healthsystem Association of PA (HAP)

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

HAP urges CMS not to revise, for more than three days, the definition of an interrupted stay to include a situation in which a patient is discharged from the LTCH and readmitted to the same LTCH for more than the proposed 3 days of the discharge. We understand that CMS will be collecting data on Medicare claims for outpatient services furnished during the time that the patients are away from the LTCH under the proposed 3-day interrupted stay policy and might possibly expand the 3-day time period in a future rule. We agree with the CMS proposal to include the days of the 3-day interruption of stay toward the total LOS if medical treatment was provided during the 3 days.

LTCHs are currently required to furnish all necessary covered services for a Medicare beneficiary who is an inpatient of the hospital either directly or under arrangements. For freestanding LTCHs, this poses more of a financial burden because of the difficult task of negotiating a fair payment with another facility or provider for these services. HAP proposes that CMS require that if an LTCH obtains, from another facility ?under arrangements,? a specific test or procedure for one its inpatients that is not available on the LTCH?s premises, that those medically necessary tests or procedures be paid at cost or the Medicare allowable rate, whichever is highest. This should apply even if it is necessary to transport the patient to another facility to receive the arranged-for tests or procedures.

Sections

Average Length of Stay Calculation

HAP supports the Centers for Medicare & Medicaid Services (CMS) proposal to align the way that days are counted for average length of stay (LOS) to the way days are counted for payment purposes. Currently, days are counted one way for payment purposes and counted another way for calculation of the average LOS. For payment purposes, long-term care hospitals (LTCH) are required to report all days of the stay during the cost-reporting period in which the discharge occurs. Furthermore, for average LOS purposes, LTCHs are required to report days associated with the corresponding cost-reporting period in which service occurred.

CMS-1263-P-T1920-Attach-1.doc

CMS-1263-P-T1920-Attach-1.doc

Submitter : **Ms. Deborah Cooper** **Date: 03/24/2004**

Organization : **Ms. Deborah Cooper**

Category : **Nursing Aide**

Issue Areas/Comments

GENERAL

GENERAL

I think requiring LTCF to report daily census and nursing staff direcetly related to Patient/Resident care is a wonderful idea.
At one time I worked in a State Veterans Home and they reported this information.

Typically staffing was much better at this facility than it is at the private facility I now work for. Staffing is a huge factor in the quality of care received. Anything that improves patient/resident care is a wonderful thing in my opinion

Submitter : **Mr. Frank Battafarano** **Date: 03/22/2004**

Organization : **Kindred Healthcare**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

Please see Kindred Healthcare's attached comments regarding: File Code: CMS-1263-P Ref: 42 CFR Part 412 Medicare Program; Prospective Payment System for Long-Term Care Hospitals; Proposed Annual Payment Rate Updates and Policy Changes; Proposed Rule

CMS-1263-P-17-Attach-1.pdf

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

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Please direct your questions or comments to 1 800 743-3951.

Submitter : **Mr. Andrew Levine, Esq.** **Date: 03/23/2004**

Organization : **Donoghue, Barrett & Singal, P.C.**

Category : **Attorney/Law Firm**

Issue Areas/Comments

GENERAL

GENERAL

Please see attached comments in Word format. If you have any trouble opening the attachment, please contact Catherine Sichol at (617) 598-6700. Thank you.

CMS-1263-P-18-Attach-1.pdf

Attach # 18

March 23, 2004

Mark McClellan, M.D., Ph.D., Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS 1263-P
P.O. Box 8010
Baltimore, Maryland 21244-1850

Re: Comments to Proposed Amendments to Prospective Payment System for Long-Term Care Hospitals: Proposed Annual Rate Updates and Policy Changes
Docket ID: CMS-1263-P; CFR Citation: 42 CFR 412
Published: January 30, 2004; Comments Due: March 23, 2004

Dear Administrator McClellan:

We are writing on behalf of Springfield Hospital LLC d/b/a Park View Specialty Hospital (the "Hospital") to submit the following comments relative to file code CMS-1263-P, which is the proposed rule published by the Centers for Medicare & Medicaid Services ("CMS") in the Federal Register on January 30, 2004. In general, we support the proposed rule and its updates to the annual payment rates for inpatient hospital services provided by long-term care hospital ("LTCH") facilities under Medicare's prospective payment system ("PPS"). Our specific comments relate to certain proposed revisions to 42 CFR § 412.531(a) and 42 CFR § 412.23(e), as further described in Section IV of the preamble entitled "PROPOSED CHANGES TO LTCH PPS RATES AND POLICY FOR THE 2005 LTCH PPS RATE YEAR."

Specifically, as further described below, the Hospital: (i) opposes the proposed extension of the interrupted stay policy for LTCHs; (ii) submits that the proposed rule should be further revised to include a provision that would allow the Administrator to waive the location requirement for any LTCH satellite or remote location that otherwise meets the provider-based criteria; and (iii) seeks clarification relative to CMS' policy on the licensure status of separately-participating LTCH facilities.

I. Proposed Extension of the Interrupted Stay Policy for LTCHs.

First, the Hospital opposes the proposed revision to the definition of an interruption of stay under 42 CFR § 412.531(a), which adds situations in which a patient is discharged from a LTCH and readmitted to the same LTCH within three (3) days of the discharge. Pursuant to this proposed change, if a patient is discharged from a LTCH and readmitted within three (3) days to the same LTCH, the subsequent readmission would not be considered a new admission and Medicare will only pay for one

discharge, based on the combined length of stay of the period prior to and after the patient's absence from the LTCH. Moreover, any treatment or medical services furnished to the patient during the three (3) day absence from the LTCH could not be billed separately to Medicare or to the beneficiary, but would be paid as "under arrangements" services to the LTCH.

The Hospital opposes the revised interrupted stay policy for several reasons. First, the revised policy results in LTCHs assuming financial responsibility for any medical services that are required by a patient but that are not available either on-site at the LTCH or under arrangement. For example, if a patient at a LTCH requires cardiac catheterization or cardiac surgery services and must be discharged to the appropriate facility for such services, the LTCH would have to reimburse that facility for all services if it readmits the patient for any reason within three (3) days thereafter. This would not only present an administrative burden on the LTCH, as it would have to track the services provided to a patient after the patient's discharge and prior to readmission, but would also present a significant financial burden to the LTCH, as it would be responsible for any charges associated with such services. Moreover, under the revised policy, the LTCH would be responsible for services provided by another provider. The Hospital opposes a policy that would require it to pay for services over which it has no control, oversight or other means by which it can ensure quality and appropriateness of care provided.

II. Waiver of Location Requirement of 42 CFR § 413.65(e)(3).

The Hospital hereby submits that the proposed rule should be further revised to include a new paragraph 42 CFR § 412.23(e)(4)(iv), which will provide the Administrator with authority to waive the location requirement of 42 CFR § 413.65(e)(3) for any LTCH satellite or remote location that otherwise meets the provider-based criteria of 42 CFR § 413.65. Below please find an overview of the specific circumstances and reasons for the Hospital's request.

A. Background.

The Hospital is located at 1400 State Street in Springfield, Massachusetts and is one of western Massachusetts' leading post-acute specialty hospitals that provides comprehensive care to medically-complex patients. The Hospital has 174 beds and offers a wide range of medical services and programs, including medically-complex pulmonary (ventilatory) care, brain injury rehabilitation, cardiac, stroke and neurology rehabilitation, spinal cord injury rehabilitation, and mental health care.

In order to help meet the needs of patients who reside in central Massachusetts, the Hospital has developed a strategic initiative to relocate up to sixty (60) beds as a provider-based satellite ("Satellite") at UMass Memorial Medical Center ("UMass") in Worcester. The Satellite will provide a much-needed step-down unit for UMass patients. Specifically, the Satellite will offer unique services such as ventilator support services for chronically-acute patients as well as pulmonary care and rehabilitation services. The Satellite will also help UMass avoid emergency room diversions, as it will allow UMass to free up acute medical-surgical beds by discharging appropriate patients to the Satellite. UMass has a high ratio of intensive care unit ("ICU") beds to acute medical-surgical beds and has a backlog of patients who would be better served in a LTCH setting. Currently, there are no alternative providers in

this area that offer chronic ventilation services. The only hospital in the area that offers these services is Fairlawn Rehabilitation Hospital of Worcester; however, this facility is an acute rehabilitation hospital that offers short-term ventilation services, which is very different from the Hospital's chronic ventilation services. There are no licensed chronic hospital facilities in central Massachusetts that serve such a different patient population other than acute independent rehabilitation facilities.

Although the Satellite proposed by the Hospital would bring needed chronic ventilation services to this area of central Massachusetts, the Hospital is prohibited from establishing this Satellite due to the location restriction contained in § 413.65(e)(3), which requires that all provider-based facilities be within a 35-mile radius of the main provider, subject to certain exceptions. The proposed Satellite will be approximately 39 miles from the Hospital and does not qualify for any of the exceptions to the 35-mile radius requirements listed in § 413.65; however, the proposed Satellite meets all other criteria contained in § 413.65.

Specifically, the Satellite and the Hospital will share common ownership and control and are subject to the same oversight and administration, thereby ensuring continuity of care between the two sites. In addition, the Satellite will be fully integrated with the Hospital as it relates to clinical services and financial administration. Further, the Satellite meets the intent of the location requirement contained in the provider-based regulation, which is that the facility be in close enough proximity to the main hospital provider in order to ensure appropriate integration of services. Although the Satellite falls outside of the 35-mile radius, it is only located four (4) miles outside this radius and is located approximately fifty-three (53) minutes away in terms of driving time.

Moreover, UMass is a full-service acute care hospital and the Hospital will be able to purchase any required physician coverage services or necessary medical supplies for the proposed Satellite from UMass. Specifically, the proposed Satellite will be able to take advantage of the various benefits that result from being located at the UMass host site, such as access to computerized tomography and magnetic resonance imaging scanning, operating room for procedures, and multiple medical staff specialties, including gastroenterology, cardiology, neurology, general and orthopedic surgery, pulmonary and infectious disease, cardiothoracic surgery, rheumatology, oncology, nephrology and neurosurgery. Such specialists are critical to the care of patients with multiple complex medical comorbidities and are often unable to consult off-site of an acute care hospital due to the lack of time. Having direct access on campus will allow for greater continuity of care and better clinical outcomes.

The Hospital has contacted the state licensing agency, the Massachusetts Department of Public Health ("DPH"), relative to the proposed Satellite. DPH has indicated that it would approve the proposed Satellite; however, the Hospital is prohibited from establishing the proposed Satellite because it does not meet the location requirement of § 413.65(e)(3), even though it meets all other provider-based criteria of § 413.65.

B. Proposed Change to Regulations.

The Hospital is therefore proposing that CMS insert an additional paragraph into its proposed

amendments to Part 412 that would permit the Administrator of CMS to grant waivers for certain LTCH satellites and remote locations that seek provider-based status pursuant to § 413.65. The proposed new paragraph would be a fourth paragraph to § 412.23(e)(4)(iv) and provide that the Administrator may waive the location requirement of 42 CFR § 413.65(e)(3) for any LTCH satellite or remote location seeking provider-based status, provided that such satellite or remote location demonstrates compliance with all other requirements of § 413.65.

In granting such waivers, the Administrator will review certain factors to determine whether the proposed LTCH satellite or remote location meets the provider-based criteria, such as whether the proposed facility shares common ownership and control with the main provider, is subject to the same oversight and administration as the main provider to ensure continuity of care, and is clinically and financially integrated with the main provider. In order to ensure that the waiver is granted in accordance with the intent of the provider-based regulation, the Administrator will review the request to ensure that the proposed LTCH satellite or remote location is located in the same area as the main provider, as determined by mileage and travel time between the two sites. In addition, the Administrator will also review any benefits provided to the proposed satellite at the host location, such as availability of physician coverage, purchased services, etc.

The proposed change will ensure that LTCHs are not prohibited from providing services to residents of areas in need of access to such services while simultaneously ensuring that such facilities continue to comply with the intent of the provider-based regulation.

III. Request for Clarification.

In addition to the proposed change described above, we are seeking clarification as to CMS' policy on the state licensure requirement for a LTCH that seeks to become a separately-participating Medicare provider. In Section IV(C)(8)(a) of the preamble to the proposed amendments, under the section entitled "Clarification of the Requirements for a Satellite Facility or a Remote Location to Qualify as a LTCH and Proposed Changes to the Requirements for Certain Satellite Facilities and Remote Locations," CMS notes:

"Because a satellite facility is not considered a separate hospital under Medicare, if a LTCH with a satellite facility is interested in "spinning off" the satellite facility and establishing the previous satellite facility as an independent LTCH, the satellite must first be separately licensed by the State."

This statement appears to conflict with our interpretation of a facility's licensure status under the previously-issued provider-based rules, which provide criteria by which a satellite of a hospital may qualify as "provider-based" for reimbursement purposes. Specifically, it was our understanding that if a satellite entity did not meet the provider-based criteria, it could obtain a separate Medicare provider number for reimbursement purposes and still operate as a satellite under the main hospital's license from the state. The statement reflected above suggests that if a satellite does not meet the 35-mile

requirement of the provider-based rules, that it would be forced to obtain a separate Medicare provider number as well as a separate license from the state. We are therefore requesting clarification as to whether a satellite that seeks to become a separately-participating Medicare provider must first be separately-licensed by the state.

We appreciate the opportunity to provide CMS with these comments on behalf of the Hospital. If you have any questions or require any additional information, please do not hesitate to contact Catherine Sichol or me at (617) 598-6700.

Sincerely,

Andrew S. Levine, Esq.
Donoghue, Barrett & Singal, P.C.
One Beacon Street, Suite 1320
Boston, Massachusetts 02108
Phone: (617) 598-6700
Fax: (617) 722-0276

Submitter : **Mr. Bradley Traverse** **Date: 03/23/2004**

Organization : **Acute Long Term Hospital Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Comments are attached

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

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Please direct your questions or comments to 1 800 743-3951.

Submitter : **Ms. Dotti Outland** **Date: 03/23/2004**

Organization : **UnitedHealth Group**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Please see the attached comment letter regarding the proposed long-term care hospital PPS payment update rule.

CMS-1263-P-20-Attach-1.doc

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

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Please direct your questions or comments to 1 800 743-3951.