Congress of the United States

Washington, DC 20515

July 25, 2003

The Honorable Thomas Scully
Administrator
Centers for Medicare and Medicaid Services
Hubert Humphrey Building, Room 314-G
200 Independence Avenue, SW
Washington DC 20201

Dear Administrator Scully:

We have serious concerns with a provision contained in the Centers for Medicare and Medicaid Services (CMS) proposed rule for the fiscal year 2004 Inpatient Prospective Payment System (PPS) that would expand the post-acute transfer policy for hospitals.

In its July report on the financial condition of hospitals, CMS details the deteriorating performance of many hospitals that rely on Medicare, particularly non-profits – 85 percent of the hospitals in America. While profitability at some hospitals is rising, it is at the expense of these poorer performing institutions. We should not impose further cuts on these struggling hospitals.

In the proposed rule, published in May 2003, CMS suggests expanding the current transfer policy to 19 additional diagnosis Related Groups (DRGs). According to CMS, this policy would reduce payments to hospitals by an estimated $160 million in fiscal year 2004 alone – leveling a serious financial impact on our nation's health care providers.

Currently, Medicare hospital patients in 10 DRGs who are discharged to a post-acute setting (skilled nursing, rehabilitation or psychiatric facility, or home with home-health care) are defined as transfers – not discharges – when their acute-care length of stay is at least one day less than the national average. The hospital is then paid at less than the full DRG rate. This current policy penalizes hospitals for efficient treatment, and for ensuring that patients receive the right care at the right time in the right setting.

Further, this proposed expansion of a misguided BBA policy undermines the basic principles and objectives of the PPS. Prospective payment systems are based on averages – cases with longer-than-average lengths of stay tend to be paid more than actual costs. The transfer policy ensures that hospitals would lose if patients are discharged after the average after the length of stay as well as before the average length of stay, if those patients receive post-acute services.

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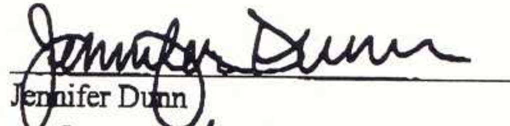
Moreover, the proposal significantly expands hospital liability for decisions not within their control. Patient and their physicians typically order and arrange post-acute care, often without the knowledge of the hospital. Yet, because hospitals must code a claim as a "transfer" or "discharge", they could be subject to erroneous allegations of fraud under the False Claims Act in an investigation of transfers incorrectly paid as discharges.

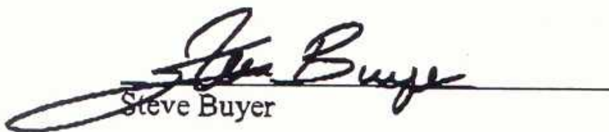
We urge you not to include this expansion of the transfer policy in the final PPS rule.

Very truly yours,

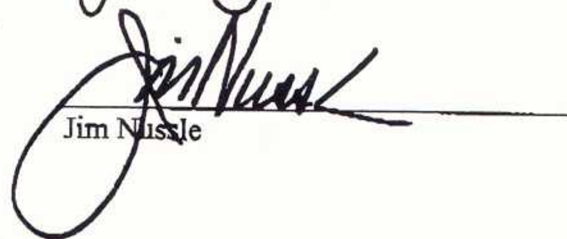
Nancy L. Johnson



Jennifer Dunn



Steve Buyer



Jim Nussle