American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

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Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attn: CMS–1483–P
P.O. Box 8011
Baltimore, MD 20244-8011

RE: Medicare Program; Prospective Payment System for Long-Term Care Hospitals: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule [CMS-1483-P].

Dear Dr. McClellan:

The American Hospital Association (AHA), on behalf of our 4,700 member hospitals and health care systems and 31,000 individual members, appreciates the opportunity to comment on the February 3, 2005 proposed rule concerning the long-term care hospital prospective payment system (LTCH PPS). The proposed rule contains the statutorily required annual payment update of 3.1 percent for the 2006 rate year, other policy changes, and a discussion of current and pending LTCH research.

Proposed LTCH PPS and Policy Changes

The AHA supports the proposed changes to the LTCH PPS, including the reduction of the fixed-loss amount for high-cost outliers, because they are based on data from the most recently filed cost reports. We also strongly support the proposal's call for a one-year extension of the exception to the three-day or less interrupted stay policy for surgical diagnostic related groups and urge the Centers for Medicare & Medicaid Services (CMS) to consider a permanent exemption for these types of cases. This would prevent LTCHs from having to cover costly surgical services for those patients who are transferred to general acute hospitals for three days or less to receive necessary surgical procedures beyond the medical scope of the LTCH.

As we did when the change was applied to general acute hospitals, we also support the transition from metropolitan statistical areas (MSAs) to core-based statistical areas (CBSAs) as the basis for creating LTCH labor market area definitions.

MedPAC Recommendations/Monitoring

The AHA applauds CMS for its efforts to build upon the June 2004 recommendations of the

Medicare Payment Advisory Commission (MedPAC) to develop patient and facility criteria for LTCHs to ensure medically appropriate admissions. Currently, this effort is being performed by CMS contractor Research Triangle Institute, International (RTI). Although the proposed rule indicates RTI will seek input from LTCHs to develop the criteria, we recommend that this step be solidified so that opportunities for exchange between CMS, RTI, and the field are explicitly added to the research plan. Other CMS contractors conducting research on significant new policy have successfully used this approach. For example, the Urban Institute conducted periodic meetings with a technical expert panel (TEP) to help develop recommendations for refining the skilled nursing facility PPS. Similarly, the RAND Corporation used a TEP to inform its research on the development and assessment of the inpatient rehabilitation facility PPS. TEPs have proven to be constructive and invaluable partners and would provide the same benefit to RTI as it works to develop LTCH patient and facility criteria. We, therefore, urge CMS to require RTI to establish a TEP to participate in the development of LTCH patient and facility criteria and to convene the panel on a regular basis to provide input on RTI's research scope, methodologies, and other relevant elements of the research plan.

Other

As the implementation date for the new payment adjustment for LTCH hospital within hospitals approaches, we again want to comment on its arbitrary nature and its limited ability to minimize overall growth of the LTCH field. Rather, this policy will limit appropriate medical access for certain patients because of the physical configuration of their referring hospital and LTCH even when the patient's clinical characteristics warrant LTCH care. We encourage CMS to instead focus on utilizing its quality improvement organizations (QIOs) and the pending facility and patient criteria to ensure that the appropriate patients are treated in LTCHs. The role of the QIOs in overseeing medical necessity in combination with the new criteria, have the potential to truly achieve CMS' goals without penalizing Medicare beneficiaries.

Thank you for the opportunity to comment on the proposed rule. If you have any questions, please contact Rochelle Archuleta, AHA's senior associate director of policy, at 202-626-2320 or via e-mail at: rarchuleta@aha.org .

Sincerely,

Rick Pollack
Executive Vice President