



**American Hospital  
Association**

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

April 30, 2007

The Honorable Pete Stark  
Chairman, Health Subcommittee  
Committee on Ways and Means  
U.S. House of Representatives  
239 Cannon House Office Building  
Washington, DC 20015

Dear Mr. Chairman:

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, I write to provide our perspective on legislative proposals addressing Long Term Care Hospitals (LTCHs).

As you know, LTCHs provide hospital-level care for very ill, medically complex, long-stay patients. LTCHs meet the same requirements as acute care hospitals, but have a unique characteristic: their Medicare patients must have an average length of stay of 25 days or longer. LTCHs can be either free-standing facilities or located within hospitals, in which case they are called hospitals within hospitals (HWH), but they both serve extremely sick patients, often with respiratory problems.

Some policymakers have expressed concern about the growth in the number of LTCHs and have questioned the role they play in providing needed post-acute care services. The AHA understands that there are several legislative proposals under your committees' jurisdiction that attempt to address these concerns. We welcome the opportunity to engage in a policy discussion and offer observations about the critical importance of LTCHs as part of the post acute care continuum.

### **Better Accountability and Sustainability for LTCHs**

The AHA wants to ensure that patients receive the right care in the right setting at the right time. To that end, the AHA supports proposals that call for criteria to differentiate LTCHs from other



post acute care settings, including the use of patient-level, facility-level, and medical necessity criteria. Currently, there are no criteria for LTCH patients. Patient-level criteria would be based on specific clinical characteristics and treatments required by patients in LTCHs. Facility-level criteria would indicate features of care provided in LTCHs. The AHA supports legislative proposals to address patient screening and medical necessity, including provisions to require the use of a common standardized patient assessment tool, based on clinical criteria, to determine whether a patient is an appropriate candidate for admission to a LTCH.

To this end, the AHA encourages the Congress to include in any relevant legislation language mandating a specific timeline for creating and implementing a common standardized patient assessment tool and appropriate medical necessity standards. We believe requiring CMS to follow a specific timeline is appropriate, and that an appropriate target date for implementation of such a patient screening tool could be accomplished within two years of enactment of LTCH legislation.

The AHA strongly supports the development of facility-level criteria that ensure certain staff are available for treating the very sick patients in LTCHs. The requirement of a physician-led, multi-disciplinary team that includes physicians, nurses, therapists, pulmonologists, and other specialized caregivers is appropriate. Such care-giving teams can determine the best plans for treating patients and the most appropriate use and mix of hospital staff.

However, the AHA is strongly opposed to mandating minimum staffing levels as a facility criterion. Staffing for high-quality patient care must be determined by an ongoing assessment of patients' needs rather than by an arbitrary number, formula, or ratio. Staffing decisions require judgment, critical thinking, and flexibility on the part of physicians, nurses and other clinical staff who best understand the needs of their patients.

Like other types of providers, LTCHs need a stable payment environment to serve their patients and plan for the future. The AHA supports proposals to require an annual update of LTCH payment rates to accommodate changes in costs and to re-weight annually the LTCH diagnosis-related groups (DRGs) in a budget-neutral manner. By providing a predictable update, Congress can ensure access to the vital services is maintained.

### **Inappropriate Limits on Medicare Beneficiary Access to Care**

In recent years, CMS has expressed concern about the growth of LTCHs. To restrict this growth, CMS imposed a policy called the 25 percent rule, which directs a HWH after a three-year transition period to accept only 25 percent of its patients from its host hospital. If more than 25 percent of a HWH's admissions come from a host hospital, the HWH's Medicare payment is reduced significantly. CMS has now proposed to extend the 25 percent rule to free-standing LTCHs.

The AHA believes that clinical characteristics of patients, not an arbitrary percentage of admissions, should be the centerpiece of any policy intended to distinguish LTCHs from general acute care hospitals. The 25 percent rule inappropriately uses referral sources to limit LTCH admissions. The AHA strongly believes that once CMS implements a patient screening

assessment tool using clinical patient criteria along with appropriate facility criteria, the 25 percent rule will be unnecessary and should be eliminated. We urge you to include language in any legislative proposal considered by your committees to eliminate the 25 percent rule upon the adoption of patient and facility criteria.

We also support legislative language to prevent CMS from extending the rule to free-standing or any other LTCHs. CMS has started research on the development of patient and facility criteria. The agency's work should be accelerated and experts in the field should be included in the process. While this work is being conducted, no additional expansion or application of the 25 percent rule should be allowed.

Finally, we oppose proposals to create a 75 percent rule for LTCHs similar to the 75 percent rule for Inpatient Rehabilitation Facilities (IRFs). The 75 percent rule for LTCHs would use patient information on diagnosis to create a facility-wide ratio for determining who may be treated in a LTCH. This approach ultimately fails patients. Diagnosis alone does not indicate whether a patient is appropriate for a LTCH; nor does it adequately address the dynamic changes in medical technology and clinical practice. A comprehensive set of clinical criteria at the patient level is what should determine appropriateness of LTCH admissions. We cannot support any type of 75 percent rule for LTCHs.

Thank you for the opportunity to express our views on LTCH proposals under consideration. As a group, LTCHs welcome the development and implementation of a common patient screening tool as soon as possible based on meaningful facility and patient criteria. Our common goal is to ensure that patients' health and well being are served appropriately. To discuss our comments in more detail, please do not hesitate to contact me or Jennifer Mallard at 202-638-1100.

Sincerely,

Rick Pollack  
Executive Vice President  
American Hospital Association

Cc: Rep. Phil English  
Rep. Earl Pomeroy  
Members, Ways and Means Committee