

April 6, 2020

The Honorable Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W., Room 445-G  
Washington, D.C. 20201

***Re: Extending COVID-19 Add-on Payment to Long-term Care Hospitals***

Dear Administrator Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including more than 250 long-term care hospitals (LTCH), our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, **the American Hospital Association (AHA) urges the Centers for Medicare & Medicaid Services (CMS) to use its authority to extend to LTCHs the existing 20% hospital add-on payment for Medicare beneficiaries diagnosed with COVID-19.** Specifically, in recognition of the increased costs of treating COVID-19 patients, the Coronavirus Aid, Relief, and Economic Security Act provided for a 20% add-on to the diagnosis-related group (DRG) rate for Medicare beneficiaries with COVID-19 treated in inpatient prospective payment system (PPS) hospitals. Extending this relief to LTCHs would support efforts by policymakers to put patients and communities first by optimizing all existing health care resources.

LTCHs are playing a critical role in supporting the growing number of general acute-care hospitals that, because they have hit their maximum capacity, must transfer COVID-19 patients to other settings. LTCHs are one of the few other settings that are able to accept these patients because they uniquely possess both ventilators and the clinicians needed to treat the virus, including pulmonologists, critical care nurses and respiratory therapists. In fact, some LTCHs are now operating as COVID-19-designated sites. Extending the 20% DRG add-on to LTCHs would help support their increasing role in fighting the pandemic.



Our LTCH members report that the treatment of COVID-19 cases is generating virus-specific additional costs due to needs such as negative pressure rooms, stringent protocols for personal protective equipment, “emergency pay” for nurses and therapists, and securing additional clinical personnel to supplement quarantined doctors and nurses. In addition, we note that COVID-19 patients on ventilators are not undergoing the typical course of care in the referring hospital, which would involve a tracheostomy, due to concerns about the higher rates of infection and death among physicians in China conducting tracheotomies for COVID-19 patients. Instead these patients are being intubated, which, while appropriate, creates a more challenging course of treatment for the patient once in the LTCH.

**The Medicare statute gives CMS extremely broad discretion to provide a 20% add-on payment for COVID-19-related LTCH discharges during the public health emergency. Indeed, the urgency of the COVID-19 emergency certainly provides ample justification for CMS to use this authority to provide this much-needed temporary relief that would benefit both patients with the virus and providers relying upon LTCHs to help relieve the strained health care system.**

Specifically, the Social Security Act (SSA) § 1886(m) sets forth the LTCH PPS by cross-referencing certain other uncodified laws that require the establishment and implementation of the LTCH PPS. Specifically, SSA § 1886(m) states: "For provisions related to the establishment and implementation of a prospective payment system for payments under [Medicare for LTCH services], see section 123 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 ["BBRA," Pub. L. No. 106-113]) and section 307(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 ["BIPA," Pub. L. No. 106-554]."

The statutory scheme contemplated by these laws is much less restrictive than the provisions authorizing other Medicare PPS systems. *See, e.g.*, SSA § 1886(d) (inpatient PPS). Indeed, both the BBRA and BIPA provide CMS with extraordinary flexibility regarding implementation of the LTCH PPS. Section 123 of the BBRA says the LTCH PPS that CMS develops "shall include an adequate patient classification system that is based on [DRGs] and that reflects the differences in patient resource use and costs, and shall maintain budget neutrality." Section 307(b) of BIPA further requires CMS to "examine the feasibility and the impact of basing payment under [an LTCH PPS] on the use of existing (or refined) hospital [DRGs] that have been modified to account for different resource use of [LTCH] patients as well as the use of the most recently available hospital discharge data. [CMS] shall examine and may provide for appropriate adjustments to the [LTCH] payment system, including adjustments to DRG weights, area wage adjustments, geographic reclassification, outliers, updates, and a disproportionate share adjustment consistent with section 1886(d)(5)(F)" of the SSA. As CMS has explained, "[a]lthough the statutory mandate for development of the LTCH [PPS] ... requires a per discharge, DRG-based system, generally the statute gives the Secretary broad discretion in designing the [PPS]." 67 Fed. Reg. 44,954, 55,968 (Aug. 30, 2002). CMS has virtually plenary "discretion to

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determine whether (and how) to make adjustments to the prospective payments to LTCHs." *Id.* at 56,014.

CMS thus has clear authority under the Medicare statute to make a 20% add-on payment for COVID-19-related LTCH discharges during the health emergency. And, to the extent that CMS believes its regulations would prohibit such an add-on, the agency could change those regulations immediately through an interim final rule. CMS has already previously used its authority to adopt changes via interim final rule in response to the COVID-19 public health emergency. As CMS explained in its March 30, 2020, COVID-19 interim final rule, "in the midst of a [public health emergency]," there is "good cause to waive notice-and-comment rulemaking," given the critical need to "offer healthcare professionals flexibilities in furnishing services while combatting the COVID-19 pandemic and [to] ensur[e] that sufficient health care items and services are available to meet the needs of individuals enrolled in Medicare." COVID-19 Interim Final Rule at 175 (pre-Federal Register Publication version).

CMS's extensive efforts to support providers urgently responding to the COVID-19 emergency are greatly valued. The AHA looks forward to continuing to partner with the agency in the fight against this pandemic. In doing so, we would appreciate your consideration of this request. If you have any questions concerning this request, please feel free to contact me, or have a member of your team contact Rochelle Archuleta, director of policy, at [rarchuleta@aha.org](mailto:rarchuleta@aha.org).

Sincerely,

/s/

Richard J. Pollack  
President and Chief Executive Officer