

July 10, 2020

The Honorable Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue SW  
Washington, DC 20201

**RE: CMS-1735-P. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals.**

Dear Administrator Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including 240 long-term care hospitals (LTCHs), and 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) appreciates the opportunity to comment on the LTCH provisions in the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2021 proposed rule for the inpatient and LTCH prospective payment systems (PPS).

This letter focuses on the LTCH provisions in the rule; we are separately submitting comments on the rule's inpatient PPS proposals.

**COVID-19-RELATED ISSUES**

**The AHA appreciates the streamlined LTCH provisions in the proposed rule, which allow LTCHs and their partners to focus on local COVID-19 responses.**

In addition, we appreciate CMS' substantial measures taken to optimize the LTCH field's contribution to the national pandemic response. The agency's ongoing support is helping LTCHs provide critical aid to beneficiaries and communities battling COVID-19 through the direct treatment of patients who have, and are recovering from, the virus.



Also, we highlight that the pandemic response has emphasized the relative strengths of each post-acute care (PAC) setting. Thus, AHA stresses our renewed concern with the underlying principle that a single payment system can accurately and reliably accommodate patients receiving care in these disparate provider settings, especially given these settings' uneven clinical capacity and highly-varied patient populations.

**Given this strong concern, we are pursuing legislative action to expand the unified PAC PPS development mandate in the IMPACT Act of 2014 to require an evaluation of the abilities of each PAC setting to prevent, mitigate and contain the intra-facility and community-spread of COVID-19 and similar infectious diseases in the future, as well as their relative abilities to treat patients with and recovering from the virus, including high-acuity cases.**

**Likewise, to develop a PAC PPS model that accounts for these concerns, we urge CMS to expand its existing work plan to address these pandemic-spurred lessons and questions in their ongoing development work with its contractors, stakeholders and other policymakers, and to discuss their findings in advance with stakeholders, as well as in the agency's final report to Congress.**

LTCH Role in the COVID-19 Response. LTCHs are playing a critical role in supporting general acute-care hospitals that, because they have reached their maximum capacity, must transfer COVID-19 patients to other settings. These LTCHs are the best alternatives for highest-acuity patients who have, or are recovering from, the virus, especially those requiring ventilator services and/or other intensive treatments or extended-stays, as LTCHs possess both the ventilators and specialized clinical teams such patients need.

As further examples of their response to the pandemic, LTCHs have expanded the availability of negative pressure rooms, implemented stringent protocols for personal protective equipment and hired additional clinical personnel to supplement existing staff and, as needed, step in for quarantined doctors and nurses. In fact, some LTCHs are now operating as COVID-19-designated sites.

The April 2020 *Health Affairs* blog by Anil Makam and MedPAC Commissioner David Grabowski (Attachment A) highlights the particular value that LTCHs bring to the fight against COVID-19, given their capacity to provide "prolonged acute and intensive care for the sickest and most complex patients needing weeks to recover after acute care hospitalizations." Also outlined are LTCH attributes that enable a relevant role in pandemic response: LTCHs' intensive care unit (ICU) beds and ventilators, critical care nurses, respiratory therapists and intensivists. These competencies are noted as facilitating specialized care for patients with respiratory failure, especially those requiring prolonged mechanical ventilation. In addition, the blog highlights three particular LTCH strengths, relative to the pandemic:

1. Caring For Patients with Other Illnesses. COVID-19 waivers have enabled general acute-care hospitals to transfer to LTCHS a wide array of patients who had, or were indirectly impacted by, the virus.
2. Providing Overflow Space for COVID-19 Patients. In regions where there are hospital bed shortages, LTCHs can serve as designated COVID-19 overflow hospitals that would care only for patients who test positive for the virus. Some LTCHs are already filling this role, which could be replicated in other areas.
3. Providing a Model for Hospitals Seeking To Add Tele-ICU Capacity. Many LTCHs have experience augmenting their ICU staffing using telemedicine, known as “tele-ICU”; this allows around-the-clock access to critical care doctors and specialists at times when they are not physically on site, such as night and weekends. This is an important model of care for other hospitals that are short on clinical personnel trained to care for critically ill patients who need respiratory support.

The blog also suggests that to help manage a COVID-19 surge, communities “should consider re-opening recently closed LTCH facilities as COVID-19-designated hospitals, especially if these facilities still have the necessary equipment (that is, hospital beds, ventilators) and infrastructure (that is, airflow units, rooms outfitted for radiation exposure, operating rooms) to care for these patients.”

LTCH Quality Reporting Program (QRP). The AHA appreciates CMS using the LTCH QRP’s extraordinary circumstances exception (ECE) policy to make data reporting optional for the fourth quarter of 2019, as well as the first two quarters of 2020. This policy provides relief from some administrative burdens while ensuring that data gathered during the COVID-19 public health emergency that may not represent true performance are not used in public reporting.

**As the pandemic evolves, we encourage CMS to consider whether applying the ECE policy for additional quarters may be warranted. Furthermore, we urge CMS to consider excluding Medicare claims data from the first two quarters of 2020 in calculating the LTCH QRP’s claims-based measures.**

CMS’s March 27 memorandum on quality reporting programs made it clear that chart-abstracted LTCH QRP measures and LTCH standardized patient assessment data do not need to be reported for Q4 2019, as well as Q1 and Q2 of 2020. However, it does not specify whether the agency also is applying an exception to claims-based measures like readmissions and Medicare spending per beneficiary. CMS is excluding Q1 and Q2 2020 claims from the claims-based measures in its hospital quality reporting and value programs. We believe it may also be appropriate to do so for LTCHs.

Lastly, exempting quarters of data from reporting has implications for the reliability and accuracy of measures in future public reporting. We urge CMS to conduct, using truncated performance periods, measure reliability analyses to ensure it has sufficient data to calculate performance accurately; CMS should then make public the results of

any such analysis. Basing public reporting on unreliable data would be highly problematic.

COVID-19 Coding by LTCHs. The ICD-10 Cooperating Parties, which include the AHA, are currently discussing a concern related to the sequencing of primary and secondary diagnosis as it pertains to hospital patients with COVID-19, including LTCH patients.

Specifically, these clarifying questions have been posed to the Centers for Disease Control and Prevention (CDC):

- Consider a general acute-care hospital patient who tested positive for COVID-19 and, prior to discharge, had three tests that each confirmed that the patient no longer had an active case of the virus. Presume that the patient was tested three times to confirm that the patient no longer had an active infection. For a patient discharged to an LTCH for treatment for acute respiratory failure on mechanical ventilation, is this ongoing acute treatment for COVID-19, which would result in the virus acting as the primary diagnosis? Or should COVID-19 be considered a lingering residual condition, and coded as a secondary diagnosis as history or sequela of the infection?

With such a case in mind, the AHA has sought clinical guidance from the CDC on when the COVID-19 can be considered resolved. The response to these questions will affect how LTCHs (and other post-acute care providers) sequence their coding of these cases.

This coding issue is particularly relevant to LTCHs and other providers of the subset of COVID-19 patients who require both intensive- and extended-hospital stays, including LTCH care, to treat related long-term lung damage, coagulation problems including pulmonary emboli, COVID-19-associated coagulopathy, chronic kidney disease, cardiac and other problems.

To address these needs, some general-acute care hospitals, especially those in hotspots, are trying to discharge formerly COVID-19-positive patients who still have related high-acuity levels to another setting as quickly as possible to make room for additional incoming COVID-19 patients. In these cases, the pending CDC guidance could have significant impact on LTCH coding and the MS-LTC-DRG assignment.

For example, a patient who no longer has active COVID-19, code U07.1 COVID-19, may not be considered a COVID-19 patient for purposes of payment and long-term evaluation of COVID-19 impact and resource needs. Also, these sample scenarios demonstrate the impact on coding sequencing on MS-LTC DRGs assignment, the associated weights and, ultimately, payment:

- If COVID-19 is assigned first with a secondary diagnosis of respiratory failure, no vent the patient would be assigned to MS-LTC-DRG 177 (Respiratory infections & inflammations w MCC; relative weight of 0.8035);
- If respiratory failure is assigned first, with a secondary diagnosis history of viral infection, no vent, then MS-LTC-DRG 189 (Pulmonary edema & respiratory failure; relative weight of 0.9616) would be assigned; and
- If a COVID-19 infection results in acute exacerbation of chronic obstructive pulmonary disease (COPD) and COPD is listed as the first diagnosis with a secondary diagnosis of COVID-19, no ventilator, then yet another payment category, MS-LTC-DRG 190 (Chronic pulmonary obstructive pulmonary disease with MCC; relative weight 0.7572), would be used.
- If COVID-19 infection results in acute exacerbation of COPD and COPD is listed as the first diagnosis with a secondary diagnosis of history of viral infection, no ventilator, then yet another payment category, MS-LTC-DRG 192 (Chronic pulmonary obstructive pulmonary disease without CC/MCC; relative weight 0.54840, would be used.

In addition, the coding and categorization of these patients will, in the long run, impact policymaker and stakeholder interpretation of the nature and scope of clinical needs and resource utilization for COVID-19 patients treated by LTCHs and other providers.

**Truly understanding this pandemic and appropriately planning for the next event require coding that accurately reflects the virus' full impact, especially for higher-acuity patients who need extensive acute and post-acute services to recover.**

**We recommend that on a short-term basis CMS urge the CDC to immediately issue definitive guidance on the application of existing ICD-10-CM codes for acute COVID-19 infections and the manifestations associated with severe COVID-19 disease.** In the longer term, CMS should urge the CDC to create unique and specific ICD-10-CM diagnosis codes that would allow the identification and tracking of the manifestations associated with severe COVID-19 disease.

This issue is currently pending review and feedback from the CDC. In addition, it will be discussed in July by the Coding Clinic Editorial Advisory Board. In the meantime, we wanted to raise this effort to CMS's attention, should it impact related regulatory activity by the agency.

#### **LTCH IMPACT FROM PROPOSAL TO USE PAYER-SPECIFIC NEGOTIATED CHARGES TO SET INPATIENT PPS RATES AND RELATIVE WEIGHTS**

CMS proposes to require hospitals, but not LTCHs and inpatient rehabilitation facilities (IRF), to include on the Medicare cost report they must file each year what the agency calls "market-based payment rate information."<sup>[1]</sup> Specifically, every hospital would be

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<sup>[1]</sup> 85 Fed. Reg. 32,460, 32,464 (May 29, 2020).

required to report “(1) The median payer-specific negotiated charge that the hospital has negotiated with all of its Medicare Advantage (MA) organizations ... by MS–DRG; and (2) the median payer-specific negotiated charge the hospital has negotiated with all of its third-party payers, which would include MA organizations, by MS–DRG.”<sup>[2]</sup> In addition, the agency requests comment regarding the use of this information when setting inpatient PPS relative weights, beginning in FY 2024. **The AHA believes that these proposals are unlawful and urges CMS not to finalize them.** AHA’s separate comment [letter](#) on the inpatient PPS provisions in this rule address this issue in greater detail.

CMS cites no authority to require hospitals to furnish median payer-specific negotiated charge information. Instead, CMS relies exclusively on an agency rule promulgated in 2019, denominated by CMS as the “Hospital Price Transparency Final Rule,”<sup>[3]</sup> which is scheduled to go into effect on Jan. 1, 2021, but it has been challenged by the AHA and others on statutory, procedural and constitutional grounds. Although the district court denied hospitals’ motion for summary judgment,<sup>[5]</sup> the hospitals have appealed that decision to the United States Court of Appeals for the District of Columbia Circuit.

Because the information to be furnished under the proposed rule would be derived from information collected under the hospital price transparency final rule, this proposal also suffers from the same legal infirmities: It is not authorized by statute and violates both the Constitution and Administrative Procedure Act. If the hospital price transparency final rule is found unlawful, CMS’s requirement for disclosure of median payer-specific charge information by MS-DRG would similarly be unlawful. The same is true as to the potential approach to change the method of calculating relative weights, beginning in FY 2024.

The AHA is hopeful that the appeals court will rule on the challenge to the hospital price transparency final rule before the end of this year. Should the hospital price transparency final rule be found unlawful, CMS would have no legal basis for requiring hospitals to disclose their median payer-specific negotiated charges by MS-DRG. If, despite the AHA’s concerns, the agency nevertheless elects to finalize them, it should not do so unless and until (1) the court upholds the hospital price transparency final rule, (2) the agency has adequately explained the basis for concluding that payer-specific negotiated charges by MS-DRG reflect resources used, and (3) stakeholders have had another opportunity to comment on the proposal.

**While the proposed rule does not discuss how this change pertains to the LTCH PPS, if implemented, it would indirectly and materially affect LTCHs, as LTCH PPS short-stay outlier and site-neutral cases are paid inpatient PPS-based rates. Given this undeniable connection, in addition to the objections already shared**

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<sup>[2]</sup> 85 Fed. Reg. at 32,791.

<sup>[3]</sup> 84 Fed. Reg. 65,524 (Nov. 27, 2019).

<sup>[5]</sup> *American Hospital Assn, et al. v. Azar*, No. 19-CV-3619 (D.D.C. June 23, 2020).

**with the court, and those addressed in greater detail in our inpatient PPS comment [letter](#), this proposed change appears to lack the type of public notice and comment from LTCH stakeholders that should be required to alter LTCH PPS payment rates.**

#### **MEDICARE BAD DEBT**

The Medicare program reimburses PPS hospitals 65% of their allowable bad debt resulting from eligible unpaid, uncollectible deductibles and coinsurance amounts, as defined in the Medicare Provider Reimbursement Manual. In this rule, CMS proposes a number of bad debt policy changes, including altering the definition of indigence and how to treat bad debt for dually-eligible beneficiaries, as well as the retroactive application of several of its proposals; however, CMS offers insufficient, unclear and, in some cases, contradictory justification for retroactive application.

**As such, we strongly urge CMS to withdraw retroactive implementation of these changes.**

**Specifically, AHA disagrees with CMS's position that retroactive implementation of bad debt policy proposals would advance the public interest.** Rather, retroactive implementation would actually have the opposite effect – providers would likely request re-opening and re-submitting cost reports out of an abundance of caution to ensure compliance with retroactive rules. **Indeed, providers would feel compelled to re-assess all previous cost reports if policies were made retroactive, leading to increased burden on provider and government resources.**

We also are troubled that the rule does not acknowledge that several of CMS' bad debt proposals would transform *recommended* activities into *mandated* actions, such that new requirements would be applied to past behavior. This fact alone would make retroactive application inappropriate since a retroactive effective date could put providers out of compliance by default, despite them having followed applicable conventions of an earlier time period.

**Given these concerns, which are more fully addressed in our inpatient PPS comment [letter](#), the AHA strongly urges CMS to withdraw proposals to retroactively apply proposed policies related to Medicare bad debt. Instead, the agency should only apply any finalized bad debt proposals to cost reporting periods ending on or after Oct. 1, 2020. In addition to retroactivity, we also have concerns with the substance of several of the proposals, which are described in detail in our inpatient PPS comment letter.**

#### **SITE-NEUTRAL CASES CONTINUE TO BE MATERIALLY UNDERPAID**

The implementation of LTCH site-neutral payment, which began in 2015, continues to transform the LTCH field. Under this policy, site-neutral cases on average have levels of clinical complexity and cost that significantly exceed their inpatient PPS-level reimbursement. Unfortunately, CMS's projections that LTCH site-neutral cases would

eventually mirror the clinical and cost profiles of similar inpatient PPS cases have not materialized.

As a result, the population of LTCH site-neutral cases dropped to 25% of all cases in 2019, as estimated by CMS, while overall LTCH case volume also has been reduced and a substantial number of facilities have closed. In fact, given that site-neutral cases will no longer receive blended inpatient PPS/LTCH PPS payments in FY 2021 and beyond, we expect this population to decrease even further once the pandemic subsides.

In addition, while the courts have ruled that the agency’s application of two 5.1% budget neutrality adjustments to site-neutral payments is allowable<sup>1</sup>, **we remain concerned that the duplicative BNAs exacerbate the impact of the policy.**

Specifically, our pre-pandemic analysis, shown in Chart 1, estimated that site-neutral cases would have been paid 28% less than they otherwise would have in FY 2020.<sup>2</sup> It is clear that the scale of the site-neutral cuts (\$1.2 billion since the policy’s inception) has unnecessarily reduced overall LTCH case volume.

**Chart 1**  
**Estimated Impact of LTCH Site-neutral Payments**  
**from FYs 2016 through 2020**

<b>Fiscal Year</b>	<b>Number of Site-neutral Cases (Estimated for FY 2019-2020)</b>	<b>Total Payments if Paid at Full Standard Rate</b>	<b>Total Blended Payments (50% Site-neutral/50% Standard Rate)</b>	<b>Difference*</b>	<b>Percent Difference</b>
2016	53,955	\$1.88 B	\$1.75 B	-\$131 M	-7%
2017	43,163	\$1.42 B	\$1.03 B	-\$382 M	-27%
2018	31,782	\$1.04 B	\$0.75 B	-\$294 M	-28%
2019	24,392	\$0.79 B	\$0.58 B	-\$214 M	-27%
2020	18,721	\$0.62 B	\$0.45 B	-\$174 M	-28%
<b>Total</b>	<b>-</b>	<b>\$5.75 B</b>	<b>\$4.56 B</b>	<b>-\$1.20 B</b>	<b>-21%</b>

Sources: FY 2016-2018 MedPAR files; FY 2016-2019 final rule and FY 2020 proposed rule CMS public use files for inpatient PPS and LTCH PPS; CMS Provider Specific File (April 2019 update).

<sup>1</sup> *Azar v. Lifecare*; U.S. District Court; Civ. No. 19-705; September 2019.

<sup>2</sup> This analysis assumes that site-neutral volume in FY 2019 & 2020 drops by the same percent per year as it did between FY 2016 and 2018 (approximately 23% per year).



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\* In FY 2016, LTCHs were paid for all discharges (including their site-neutral cases) at the LTCH PPS standard rate until the start of their first cost reporting period beginning after Oct. 1, 2015; this accounts for the smaller difference in FY 2016 between the blended payment and the payment at the full standard rate.

**Finally, to ensure that LTCH payment policy will reflect post-pandemic utilization patterns, we urge CMS to exclude LTCH data from the public health emergency period when considering the long-term treatment of this and other LTCH issues, rather than use data that reflect the temporarily-altered clinical care pathways of the pandemic.**

We thank you for the opportunity to comment on this proposed rule. If you have any questions concerning our comments, please feel free to contact Rochelle Archuleta, director of policy, at [rarchuleta@aha.org](mailto:rarchuleta@aha.org).

Sincerely,

/s/

Thomas P. Nickels  
Executive Vice President

## AHA ATTACHMENT A

HEALTH AFFAIRS BLOG, APRIL 13, 2020

How Can We Ramp Up Hospital Capacity To Handle The Surge Of COVID-19 Patients? Long-Term Acute Care Hospitals Can Play A Critical Role

[Anil N. Makam](#), [David C. Grabowski](#)



Health care systems in many regions of the US are overwhelmed—facing an unprecedented surge of COVID-19 patients with acute respiratory failure without adequate supplies, space, or staff to care for them. [We simply don't have nearly enough hospital capacity](#) to manage the national crisis. As we search for new ways to expand hospital capacity, we should not overlook a critical resource, [long-term acute care hospitals \(LTACHs\)](#).

LTACHs can play an important role in regions affected by COVID-19. LTACHs are a sector of postacute care in the US that provides prolonged acute and intensive care for the sickest and most complex patients needing weeks to recover after acute care hospitalizations. As such, LTACHs have intensive care unit (ICU) beds and ventilators, and they employ critical care nurses, respiratory therapists, and intensivists. LTACHs [specialize in caring for patients with respiratory failure](#), especially those who require prolonged mechanical ventilation.

### Three Roles For LTACHs During The COVID-19 Pandemic

LTACHs can help fill three major gaps in our preparedness and response to COVID-19:

#### **Caring For Patients With Other Illnesses**

First, LTACHs can care for non-COVID-19 patients who require hospitalization, including for critical illness, to reserve acute care hospital beds for COVID-19 patients. Typically, to maintain accreditation, LTACHs must show that their patient populations have an average length-of-stay of 25 days. The [Centers for Medicare and Medicaid Services has temporarily relaxed this rule](#) during the pandemic and is

allowing LTACHs to exclude any admissions related to the COVID-19 emergency from the required 25-day average. This added flexibility makes it easier for acute care hospitals to transfer patients with less complexity and severity of illness who need far fewer than 25 days of hospital care to recover, and it allows LTACHs to accept these patients without concern about the average length-of-stay metric. Additionally, the [Coronavirus Aid, Relief, and Economic Security \(CARES\) Act](#) waived two additional provisions to increase LTACH access, including the [site-neutral payment policy](#), which stipulates reduced financial reimbursement for LTACHs to admit patients of lower acuity, and the [50-percent rule](#), which requires that greater than 50% of LTACH patients meet site-neutral payment criteria for full reimbursement. Collectively, these policies enable LTACHs to expand the types of patients that they treat.

### **Providing Overflow Space For COVID-19 Patients**

Second, in regions with a shortage of hospital beds, LTACHs can serve as designated COVID-19 overflow hospitals that would care only for patients who test positive. This model is being implemented in a few LTACHs already (see [here](#) and [here](#)) and could be scaled up elsewhere.

### **Providing A Model For Hospitals Seeking To Add Tele-ICU Capacity**

Finally, many LTACHs have experience with telemedicine for their ICU staffing ([tele-ICU](#)). While required to have 24/7 on-site physician presence, LTACHs are often staffed by physicians not trained in critical care medicine, especially at night or during weekends, and rely on tele-ICU for consultations for critically ill and mechanically ventilated patients. As states seek to rapidly boost the number of ICU beds and access more ventilators and supplies, hospitals may come up short on the number of health care workers trained to care for critically ill patients who need respiratory support. Hospitals could fill the gap by quickly adopting tele-ICU models used by LTACHs and rural hospitals. For this to happen, we will need to ensure that sufficient intensivists are available to handle the surge in new tele-ICU visits. Moreover, hospital ICUs and other ICU overflow sites will need to be provided with telemedicine equipment and high-speed internet.

### **Protecting LTACH Patients And Staff**

Patients in LTACHs typically are elderly and have [prognoses](#) similar to or worse than those with advanced cancers or other end-stage diseases. Consequently, a COVID-19 outbreak in an LTACH could be catastrophic, with higher mortality than that [observed in nursing homes with outbreaks](#). Thus, LTACHs with COVID-19-naïve patients should accept COVID-19 positive patients only if they can ensure the strictest of infection prevention safeguards. Before accepting COVID-19 patients, LTACHs need to have adequate supplies of personal protective equipment, provide staff training, and ensure that an adequate number of negative pressure rooms are available. Even before the pandemic, one of the main patient risks associated with LTACH admissions is the potential to contract an infection caused by [multidrug resistant bacteria](#). These nosocomial infections are more common in LTACHs than in hospitals and skilled nursing facilities.

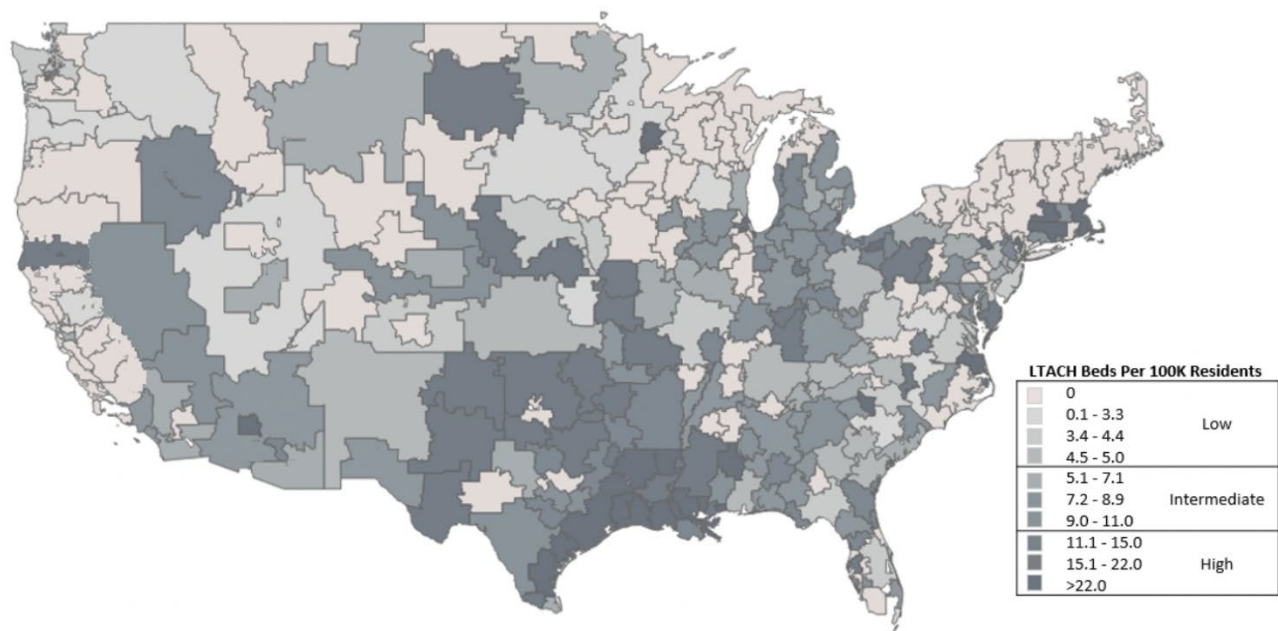
Patients transferred to LTACHs should ideally be tested for COVID-19 prior to transfer. However, test results reflect the level of viral load at the time of testing, and tests may not come up positive when patients with COVID-19 are in the asymptomatic incubation phase of the disease. Therefore, special precautions are indicated for all new admissions to prevent transmission from asymptomatic patients or

those with mild illness that may go undetected. To avoid adverse outcomes from new admissions, LTACHs should implement universal testing for all prospective non-COVID-19 positive patients. If LTACHs do not have the capacity to test, they should standardize screening of clinical signs and symptoms (cough, shortness of breath, fever), and they should [follow standard infection prevention recommendations for patients with suspected COVID-19](#) for all new admissions for the first [14 days](#), the incubation period for COVID-19.

#### Reopening Recently Closed Long-Term Acute Care Hospitals

LTACHs may not provide a viable solution to capacity challenges in some parts of the country. The 391 LTACHs in the US are [not distributed evenly](#); some regions have few, and others have many (see exhibit 1). The number of LTACHs is low in Seattle, Washington, and New York City, where the strains on hospital capacity are greatest. On the other hand, in Texas, Oklahoma, and Louisiana, LTACHs are available in sufficient numbers to play a significant role in the COVID-19 response.

#### Exhibit 1: Regional supply of LTACHs by hospital referral region



Source: Makam AN, Nguyen OK, Kirby B, Miller ME, Xuan L, Halm EA. Effect of site-neutral payment policy on long-term acute care hospital use. *Journal of the American Geriatrics Society*. 2018;66(11):2104-11. Notes: Regional LTACH supply is defined at the hospital referral region (HRR) level (using 2010 census data) as the number of LTACH beds in 2012 per 100,000 residents. The 304 HRRs in the continental US were categorized as low supply ( $\leq 5.0$  beds per 100,000 residents), intermediate supply (5.1 to 11.0 beds), or high supply ( $\geq 11.1$  beds), with gradations within each category.

Implementation [of site-neutral Medicare payment policy](#) in 2015 reduced the financial incentive for LTACHs to admit patients of lower acuity. As a result, there [have been several LTACH closures in the past few years](#), mostly in regions with excess supply. To expand the capacity of acute care hospitals, state

officials should consider re-opening recently closed LTACH facilities as COVID-19-designated hospitals, especially if these facilities still have the necessary equipment (that is, hospital beds, ventilators) and infrastructure (that is, airflow units, rooms outfitted for radiation exposure, operating rooms) to care for these patients.

#### Conclusion

During this unprecedented international crisis, LTACHs offer additional opportunities to prepare for and manage the surge of COVID-19 patients experiencing respiratory failure. Now is the time to leverage these opportunities.

#### Authors' Note

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