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Association**

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June 21, 2013

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-1599-P, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Medicare Program; Proposed Rule (Vol. 78, No. 91), May 10, 2013

Dear Ms. Tavenner:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations – including 273 long-term care hospitals (LTCHs), and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed changes to the fiscal year (FY) 2014 LTCH prospective payment system (PPS). We will comment separately on the agency's proposed changes to the inpatient PPS.

The AHA is extremely concerned about two provisions in the proposed rule – CMS's plans to allow the current "25% Rule" relief to expire, and its current research agenda on major reforms for the LTCH PPS. Both of these changes would inhibit the ability of LTCHs to continue to treat the sickest patients – a role that is notably distinct from other provider settings. CMS's proposals are drastic and ill-timed given the fundamental transformation of the health care delivery system. LTCHs are adapting to a wide array of regulatory demands, including the rollout of the LTCH quality program, the transition to ICD-10, implementation of electronic medical records, and efforts to integrate with other providers and payers in their communities. These factors, paired with the shift toward paying for value instead of volume, present LTCHs with substantial regulatory challenges and uncertainty. Given this environment, **the AHA urges CMS to avoid further exacerbating this period of demanding transition and instead maintain the current 25% Rule relief. We also urge the agency to reconsider the direction and scope of its current research and instead concentrate on less severe means of raising the minimum clinical standards for LTCHs.**



In addition to these major concerns, this letter also contains the AHA's feedback on proposed changes to the LTCH quality reporting (LTCHQR) program.

FULL IMPLEMENTATION OF THE 25% RULE

Under the FY 2014 proposed rule, CMS would allow the hold on full implementation of the 25% Rule policy to expire for cost reporting periods on or after October 1, 2013. The 25% Rule reduces Medicare payments to LTCHs for selected referrals. Specifically, a payment reduction is applied to those referrals that exceed an LTCH's referral threshold. Under the full implementation of the policy, most LTCHs would have a 25 percent-threshold, which results in a payment reduction for referrals from the same hospital that exceed 25 percent of an LTCH's discharges over a one-year period. Referrals that were outliers during the stay at the referral hospital would be exempt from the payment cut. In addition, certain LTCHs, such as rural LTCHs, have a higher, more lenient threshold. For referrals that exceed the designated threshold, the Medicare payment is reduced, frequently to an inpatient PPS-equivalent amount.

The AHA opposes CMS's proposal to allow full implementation of the 25% Rule. If CMS proceeds with full implementation of the 25% Rule, Medicare payments for high-severity patients who are expected to need a long stay – the appropriate target population for LTCHs – would be significantly reduced, often to a level that is well below cost. This could potentially put these patients' access to critical LTCH care in jeopardy. Therefore, full implementation of the 25% Rule would serve as a barrier to patient access to LTCH services by imposing a material payment reduction for patients who are medically suitable for this specialized setting. Specifically, the policy reduces payments based on the *origin* of the LTCH referral, with no regard for the patient's medical necessity for LTCH services. This concern has been discussed extensively by stakeholders and acknowledged by CMS and Congress, yet the agency still proposes to allow the policy to be fully implemented starting this fall. Finalizing this proposal would seriously threaten beneficiary access to the unique, specialized services offered by LTCHs.

The AHA urges CMS to reconsider its proposal to fully implement the 25% Rule and instead maintain the policy at current levels. The AHA continues to believe that the development and application of clinical patient and facility criteria to define LTCHs is far preferable to the 25% Rule. For example, the AHA supports efforts to redirect to other settings any LTCH patients who are not high-acuity, long-stay cases based on patient criteria. This would allow LTCHs to, in the meantime, continue the positive trend identified by both the Medicare Payment Advisory Commission (MedPAC) and CMS of treating a population with rising average level of medical acuity. (See "LTCHs Fill a Unique Role in the Continuum of Care.")

CMS RESEARCH ON LTCH PAYMENT REFORM

CMS is engaged in research that would shift payments for a majority of LTCH patients from the LTCH PPS to the inpatient PPS. CMS has estimated that 67 percent of LTCH cases would be subject to inpatient PPS-level payments. The remaining patients – those whom CMS would

deem chronically, critically ill (CCI) – are a subset of the highest-acuity patients treated in LTCHs, and their cases would continue to be paid under the LTCH PPS. To be deemed a CCI case, the patient must have one or more of the five clinical factors listed below, and receive eight or more days of intensive care unit (ICU) or coronary care unit (CCU) services during an immediately prior stay in a general acute hospital:

- Prolonged mechanical ventilation;
- Tracheotomy;
- Multiple organ failure, stroke, intercerebral hemorrhage, or traumatic brain injury;
- Sepsis and other severe infections; and
- Severe wounds.

The product of CMS’s research would be a notable departure from its prior goal for the LTCH PPS, as stated in 2012 and before, of establishing criteria to identify the types of patients who would benefit from the unique services LTCHs provide. It makes a dramatic and unfounded leap beyond addressing the problem of LTCHs treating patients who are not both long-stay and high-complexity cases and could dramatically lower payments for high-severity cases that do not fall into the CCI category. **The AHA believes that rather than using an arbitrary ICU/CCU length-of-stay criterion, patients with high acuity and significant resource use should be the focus of LTCH payment reform. As such, we urge CMS to continue researching clinical factors that could be used to define LTCH patients, but to re-examine its reliance on the ICU metric.**

LTCHs Fill a Unique Role in the Continuum of Care

The LTCH patient population is unique from the population found in other provider settings. Specifically, LTCH patients have an average length of stay, 27.2 days, that is significantly longer than that of patients in general acute hospitals, 5.1 days, or even ICU patients in general acute hospitals, 6.7 days. In addition, LTCHs’ pronounced focus on treating patients with the highest level of severity of illness is unmatched by other hospital settings. The LTCH case mix continues to trend toward even higher acuity levels, per analysis by CMS and MedPAC. In fact, CMS’s FY 2014 proposed rule on the LTCH PPS notes the trend of growing acuity:

...the shift toward higher severity levels is evident not only within more complex conditions where the patient load is increasing, but also within the less complex conditions where the relative patient load has been declining.”

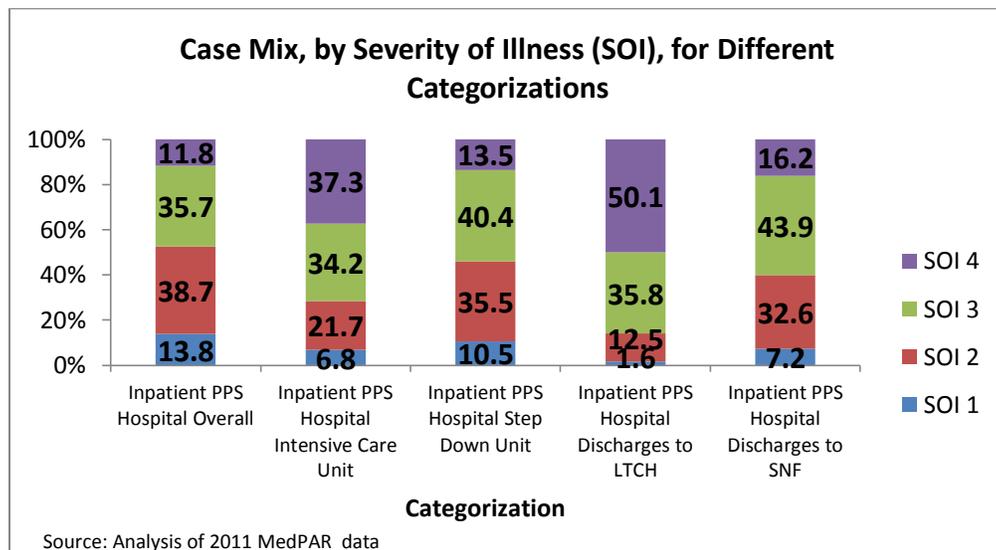
A July 2012 report for CMS by Kennell and Associates supported this finding:

“...the data on primary conditions, the mix of co-morbidities and the mix of major treatments all indicate a higher level of clinical complexity in LTCHs relative to other settings and suggests related differences in care organization, professional staffing and payment across these providers.”

In addition, the Kennell report, in comparing services and patients in LTCHs, other post-acute settings, general acute hospitals, and hospital step-down units, found LTCHs had a unique clinical focus:

“...LTCHs are much more focused on intense respiratory care, and they also have a much higher proportion of patients receiving the types of treatments normally associated with higher nursing efforts...[with] higher proportions of patients with central lines, wound care procedures and TPN [total parenteral nutrition].”

To analyze the distinct role of LTCHs relative to other settings, the AHA examined discharge data from general acute hospitals to compare overall severity of illness for various settings. These data are presented in the bar chart below and show that patients discharged to LTCHs already have the highest severity when compared to other settings. For example, 50 percent of inpatient PPS patients discharged to an LTCH have a severity of illness (SOI) level 4 (extreme severity) compared to only 37 percent of ICU patients, as measured by the APR-DRG grouper using 2011 Medicare claims data.



In prior policy discussions, both MedPAC and CMS have compared the LTCH role to that of step-down units in general acute care hospitals. Step-down units provide a level of care that falls between that of ICUs and medical-surgical units in general acute hospitals. These data call into question the accuracy of comparing the clinical role served by LTCHs with that of step-down units, given that the SOI distribution for step-down units is much closer to the SOI distribution for skilled nursing facilities (SNFs) than LTCHs. For example, 86 percent of patients discharged to LTCHs had an SOI level 3 or 4, compared to 54 percent of patients in hospital step-down units, and 60 percent of patients discharged to SNFs.

LTCHs Provide Value for Very Sick Patients

As noted by CMS, prior studies assessing the value of LTCH services for the *overall* LTCH population have found mixed results. But when looking at *very sick* patients, the setting has been shown to provide value. For example, CMS states in the proposed rule that “LTCHs are

appropriate providers for treating severely ill, but medically stable, patients with complex medical conditions” (p. 27671). Further, MedPAC research found that LTCHs provide beneficial and cost-effective services for certain complex patients (*ibid*). The transition in recent years to a mix of higher-acuity patients in LTCHs is noteworthy, as LTCHs are appropriately directing their services to patients for whom they provide the greatest value. The AHA agrees that patients should be treated in the most clinically appropriate settings and supports the acceleration of this shift by establishing minimum LTCH admissions standards. Such standards should focus the field to an even greater extent on treating the highest-acuity, long-stay patients and discouraging the admission of patients with low acuity and those medically suitable for admission to an inpatient rehabilitation facility, inpatient psychiatric facility or SNF.

In addition to the trend toward higher-acuity LTCH admissions, recent research on LTCH effectiveness¹ supports the value of the LTCH model of care:

*In our national study of elderly Medicare beneficiaries, patients with chronic critical illness transferred to LTACs experienced similar 1-year survival and lower 180-day hospitalization-related costs compared with patients who remained in acute care ICUs. These results were robust to varying assumptions about patients and hospitals eligible for the analysis, with some sensitivity analyses suggesting that LTACs might improve survival for patients when the population of eligible patients is expanded to include those earlier in their ICU course. **Our study provides important conceptual support both for the LTAC model in chronic critical illness and for the utility of comparative effectiveness research in evaluating the organization of care for the critically ill.** [Emphasis added.]*

Further, based on site visits with general acute hospitals, the July 2012 Kennell Report found that LTCHs’ concentrated clinical programs may be difficult for general acute hospitals to provide:

...general acute hospitals often mentioned the advantages of LTCHs’ greater provision and better organization of therapy, as well as their more structured weaning protocols. At several IPPS sites we asked why their own critical areas could not provide this added level of therapy support. Clinicians in two hospitals commented that they staff the critical care areas for the more typical short-stay ICU patients, and that efficient nursing and therapy staffing for the long-term critically ill patient is problematic unless several such patients need these services at the same time.

We urge CMS to focus its research on defining the clinical characteristics of patients in LTCHs.

¹ “Effectiveness of Long-term Acute Care Hospitalization in Elderly Patients with Chronic Critical Illness,” J.Kahn, MD, et al. *Medical Care*. January 2013. The study defined “chronic critical illness” as patients having received mechanical ventilation and 14 or more ICU days.

ICU Metric Does Not Correlate with Severity of Illness and Excludes Appropriate LTCH Patients

Under CMS’s reform, only the LTCH patients who fall in the CCI category would be eligible for payment under the LTCH PPS. The agency defines CCI patients as those that receive eight or more days of ICU or CCU services during the prior stay in a general acute hospital, and have a qualifying medical condition.

CMS has not yet issued its clinical data specifications for defining the CCI category. However, CMS staff, in communication with the AHA, estimated that approximately 33 percent of the LTCH population would qualify as CCI cases. The AHA will conduct a close examination of the CCI population and submit additional feedback to CMS on the CCI metric, once CMS provides the CCI data parameters, which are expected after the proposed rule’s comment period.

For now, we have begun to assess whether the criterion of eight ICU days is a reliable metric for dividing the LTCH population into two distinct categories. This assessment is important given CMS’s heavy reliance on ICU days as a key threshold for identifying those LTCH cases that would continue to receive LTCH payments. **Our review of the 2011 claims data shows that 65 percent of LTCH cases did not receive eight or more days of ICU services during the immediately prior stay in a general acute hospital, and therefore do not satisfy the ICU component of the CCI definition, which is excessive given the concerns with the ICU metric that we raise below.**

LTCH cases with eight or more ICU days in the prior hospital stay fall into 382 of the 751 Medicare-severity (MS)-LTC-DRGs. As shown by the data below, for some MS-LTC-DRGs, patients with eight or more ICU days do not appear to be materially distinct from those using fewer ICU days. Specifically, as shown in Table 1, we found that for these common LTCH conditions, patients had similar numbers of MS-LTC-DRG complications and comorbidities or major complications and comorbidities (CC/MCC) and similar LTCH lengths of stay regardless of whether they received more or less than eight days of ICU services.

Table 1: Comparison of Patient Characteristics for Patients with Eight or More and Less than Eight ICU Days for Selected MS-LTC-DRGs

2011 SAF Data Selected DRGs from analysis LTCH cases referred from IPPS hospital within 24 hours	MS-LTC-DRG 871 Septicemia Or Severe Seps w/o MV 96+ Hours w/MCC		MS-LTC-DRG 004 Trach w MV 96+ or PDX exc face, mouth & neck w/o major O.R.		MS-LTC-DRG 189 Pulmonary Edema & Respiratory Failure	
	ICU <= 8 days	ICU = 8+ days	ICU <= 8 days	ICU = 8+ days	ICU <= 8 days	ICU = 8+ days
Average No. of CC/MCCs	5.7	6.7	9.3	9.3	4.6	5.3
Length of Stay in LTCH	22.9	22.3	49.2	47.7	20.7	22.2
% of Cases in MS-LTC DRG	69%	31%	38%	62%	47%	53%

And, in fact, we found that 84 MS-LTC-DRGs in which patients with *fewer* than eight ICU days in the prior hospital stay had a *greater* number of average CC/MCCs. This finding indicates that among LTCH patients, greater ICU usage may not correlate with greater severity of illness. **The AHA believes that rather than using an arbitrary ICU usage criterion, patients with high acuity and significant resource use should be the focus of LTCH payment reform. As such, we urge CMS to continue researching a set of clinical criteria to define LTCH patients, but to re-examine its reliance on the ICU metric.**

In addition to concerns that CMS's narrow and arbitrary ICU metric excludes 65 percent of LTCH cases and fails to divide LTCH patients into clinically distinct subgroups, we are concerned that the CCI definition excludes some of the sickest patients treated in LTCHs. LTCHs already are more concentrated on treating extreme severity than ICUs, with 50 percent of LTCH patients having extreme SOI (level 4) and only 37 percent of ICU patients at this level. CMS did not address this point in the rule, nor did the agency discuss how the overall clinical status and SOI for CCI patients compares with that of non-CCI patients in LTCHs. **It is inappropriate and unwarranted to exclude from the CCI definition LTCH patients who have extreme or major SOI. The AHA believes that these patients with high acuity and long stays, in addition to CCI patients, are precisely the patients LTCHs should focus on treating.**

Under the potential reforms, CCI patients in general acute hospitals and LTCHs would receive the same payment. Yet, the rule presented no analysis comparing the clinical status and medical resources needed by CCI patients in both settings. We urge CMS to conduct such analysis comparing severity of illness, length of stay, and treatments for these two populations. In addition, we recommend that CMS report on proposed CCI payment amounts relative to current inpatient PPS and LTCH PPS payment for CCI cases, including reporting such comparisons at the DRG level.

CMS's Proposal Would Greatly Affect the Inpatient PPS

CMS's proposals to make payments for many LTCH services through the inpatient PPS would have extensive ramifications for general acute hospitals paid under the inpatient PPS. We are concerned that CMS has not sufficiently explored and explained all such consequences for stakeholders. We would expect that a review of the impact of potentially transitioning many LTCH patients for whom services would be paid under the inpatient PPS also would include an assessment of *net* improvements in Medicare payments and quality of care, including readmissions, for each of these subsets of both the general acute hospital and the LTCH populations: CCI patients, non-CCI patients, short-stay outliers, non-short stay cases, patients with SOI level 3 and, separately, SOI level 4.

We strongly encourage CMS to re-evaluate and redirect its current LTCH efforts away from the arbitrary ICU metric and toward the clinical characteristics of patients, including SOI, to identify the types of patients who would benefit from the unique services of LTCHs.

LTCH QUALITY REPORTING PROGRAM

The ACA mandated the establishment of a quality reporting program for the LTCH PPS. Failure to meet the data submission requirements and deadlines of the program subjects LTCHs to a 2-percentage point reduction to their annual market-basket update, beginning in FY 2014. CMS proposes no new measures for the FY 2014 or FY 2015 program, but does make proposals for FY 2017 and FY 2018.

Updates to Previously Finalized LTCHQR Measures

Health Care Personnel Influenza Vaccination. For the FY 2016 LTCHQR program, the agency proposes to delay the health care personnel flu vaccination measure data collection period until Oct. 1, 2014 through Mar. 31, 2015, with a submission deadline of May 15, 2015. This would allow LTCHs to be able to collect and report data from the entire 2014 – 2015 flu season. Similarly, for FY 2017 payment determination, data collection would occur from Oct. 1, 2015 through Mar. 31, 2016, with a data submission deadline of May 15, 2016. **The AHA supports these proposals.**

Patient Influenza Vaccination Measure. CMS proposes modifications to the previously finalized data collection and submission timeframes for the patient flu vaccination measure in order to accommodate the implementation of the LTCH CARE Data Set (version 2.01). Additionally, the agency proposes to base the measure calculation and subsequent public reporting of the measure on the time period of an influenza season, which is Oct. 1 through Mar. 31 of the subsequent year. **The AHA supports these proposals.**

FY 2017 Measurement Proposals

CMS proposes to add three measures to the LTCHQR program in FY 2017. All three proposed measures were reviewed by the Measure Application Partnership (MAP). The MAP is a multi-stakeholder board charged with making annual recommendations to the Secretary of Health and Human Services (HHS) regarding which measures should be included in national quality reporting programs.

None of the three proposed measures received the MAP's full recommendation because MAP members felt the measures had not been fully specified or tested for the LTCH setting. **The AHA shares the MAP's concern; CMS should ensure the measures have been appropriately specified and tested for LTCHs before they are proposed for the LTCHQR program.** Our measure-specific comments are discussed below.

Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteremia. CMS proposes to collect this healthcare-associated infection (HAI) measure via the same data collection and submission framework as the central line associated-bloodstream infection (CLABSI) and catheter-associated urinary tract infection (CAUTI) measures currently finalized for the program.

The AHA does not support the inclusion of the MRSA measure in the LTCHQR program because it has not yet been tested for use in LTCHs. Although the agency notes that 40 LTCHs voluntarily reported MRSA data to the National Healthcare Safety Network between January 2012 and January 2013, this voluntary reporting activity does not constitute formal

testing. In fact, the only MRSA performance data cited in the rule are based on 2009 Medicare claims data, and the agency acknowledges that LTCH claims data lack a present on admission indicator that would help determine whether the MRSA was acquired before or during hospitalization, thus compromising the accuracy of the agency's analysis. We agree that reducing HAIs is an important goal, and that successfully achieving that goal may require measurement in multiple care settings. However, in order to accurately assess the occurrence of MRSA in a specific LTCH and compare that facility's results to those of others, the measure's specifications must be shown to obtain accurate results in LTCHs. Given that LTCHQR measure scores will ultimately be publicly reported, it is essential that the measures are rigorous enough to produce credible results.

We encourage CMS to update the measure specifications so they are appropriate to LTCHs and to formally test those specifications in LTCHs. The testing results should then be submitted for review to the National Quality Forum (NQF). If NQF endorses the updated specifications, then CMS should seek MAP review of the updated measure, and consider re-proposing it for the LTCHQR program in a future rule. By following this process, CMS, LTCHs and patients will be assured that the measure obtains accurate results, and that it discerns real differences in performance across entities.

Clostridium Difficile (C. Diff.). Similar to MRSA, CMS proposes to collect C. Diff. using the same framework as the CLABSI and CAUTI measures. **For the same reasons as the MRSA measure, the AHA does not support the inclusion of the proposed C. Diff in the LTCHQR program.** As with MRSA, the current NQF-endorsed specifications for C. Diff do not include LTCHs. CMS should update the measure specifications, and follow the same process outlined above for MRSA to obtain NQF endorsement and MAP review of the updated C. Diff. measure.

Unplanned All-Cause, All-Condition Readmissions. This proposed measure assesses readmissions to LTCHs and acute-care hospitals and is heavily based on the hospital-wide all-cause unplanned readmission measure currently in the hospital inpatient quality reporting program (IQR). The proposed measure captures readmissions of Medicare patients within 30 days of an LTCH discharge to the community or another care setting of lesser intensity (e.g., SNFs, home health agencies, inpatient rehabilitation facilities) to an acute-care hospital or LTCH. The measure excludes transfers from an LTCH to either another LTCH or to an acute-care hospital. The proposed LTCH readmission measure also excludes the same "planned" readmissions (e.g., chemotherapy, labor/delivery, transplantation) as the IQR measure, but CMS also has added several other exclusions that it believes are appropriate for the LTCH patient population, such as amputations, removal of feeding and tracheostomy tubes, and some colorectal procedures.

The AHA does not support the inclusion of the proposed readmissions measure in the LTCHQR program for FY 2017 because it has yet to obtain NQF endorsement. Thus, we urge CMS to seek NQF endorsement of the measure and subsequently seek a MAP review. CMS could then re-propose an NQF-endorsed measure in a future rule. We believe an NQF review would allow the field to more fully examine the measure specifications, as well as any testing data. Indeed, several of our LTCH members have already expressed concern about the adequacy of the "planned readmission" exclusions in the proposed measure. For example, the

measure's planned readmission exclusions do not include burn patients who often require extensive care post hospitalization. An NQF endorsement evaluation could identify other measurement issues and provide a mechanism for those concerns to be adequately addressed in the measure.

The AHA also is very concerned that because the basic measurement approach is similar to the IQR readmissions measures, the proposed LTCH measure fails to exclude readmissions unrelated to the initial reason for admission and does not adjust for socioeconomic factors.

First, the measure should exclude readmissions unrelated to the initial reason for admission because such readmissions are not indicative of the quality of care provided during the initial hospitalization. For example, if a discharged patient was hospitalized for the treatment of pneumonia, and that patient fractured his hip from a fall in the shower five days after discharge, that readmission would be counted towards the hospital's total. While re-hospitalization is obviously the correct approach in this instance, we do not believe that readmission is indicative of the quality of pneumonia care that patient received.

Also, the AHA continues to urge CMS to incorporate an adjustment for socioeconomic factors into its readmissions measures. All hospitals, regardless of the circumstances they face, aim to provide the highest quality of care to the patients and families that rely on them. Applying an appropriate adjustment for socioeconomic factors would acknowledge the reality that hospitals cannot always control or change structural barriers to accessing resources that can help prevent readmissions.

Indeed, hospital readmissions are affected by a variety of factors, many of which are beyond the control of hospitals. The health care infrastructure of a community greatly impacts readmissions rates. A lack of access to primary care, mental health services, physical therapy and other rehabilitative support can increase the likelihood of readmissions. Other factors can include lack of public transportation (which can affect access to medical care), and inconsistent access to appropriate foods to aid in patient recovery. While hospitals should do all within their power to care for and assist the patients in challenging circumstances, they should not suffer reputational harm from unfavorable readmissions scores due to community issues.

Further, dual-eligible status is a powerful predictor of readmission risk and is a factor that is readily available to CMS. It reflects the hospital's share of impoverished *Medicare* patients, and since the readmission measures include only Medicare beneficiaries, an adjustment based on hospitals' proportion of dual-eligible beneficiaries is appropriate and will enable fairer comparisons of performance among hospitals. CMS should explore dual-eligible status as an adjustment factor for the LTCH readmissions measure to account for socioeconomic difference in communities.

To do so, in reporting performance on the readmissions measure, CMS could separate LTCHs into quartiles based on the proportion of their patients that are dual eligible. Once all eligible hospitals are divided into quartiles, CMS could then determine the average readmissions rate within each quartile. Finally, CMS could calculate an excess readmissions ratio for hospitals using the existing readmissions measures. However, those measures would use each quartile's

average readmissions rate, rather than the average readmissions rate of all hospitals in the program. Thus, the readmissions score would be dependent on how hospitals perform compared to hospitals with a similar proportion of duals. We believe adjusting the measures in this fashion could facilitate a much fairer comparison of LTCH readmissions rates.

FY 2018 Measurement Proposal

CMS proposes one new measure for the FY 2018 LTCHQR program — the percent of residents experiencing one or more major falls with injury. CMS proposes that this measure be collected using the LTCH CARE Data Set. While this measure is NQF-endorsed, the measure specifications and testing data used to obtain NQF endorsement are specific to nursing homes and SNFs. **Therefore, the AHA does not support the inclusion of this measure in the LTCHQR program. Similar to the measurement proposals for FY 2017, the AHA is concerned that this measure has not been fully specified or tested for the LTCH setting.** While falls with injury are important patient safety issues, CMS must select measures that accurately assess falls in the care setting in which they occur.

We encourage CMS to update and test the existing measure specifications, or to identify an alternative measure of falls with injury that is better suited for the LTCH environment. **No matter which path the agency chooses, the measure must be reviewed and endorsed by NQF for use in LTCHs.** We also urge the agency to seek MAP review of any measure before proposing it for the LTCHQR program.

Data Reporting and Submission Requirements

CMS makes several detailed proposals on the measure data collection and submission timeframes for the FY 2017 and FY 2018 program. **The AHA supports the proposed collection and submission timeframes for the measures previously finalized for the program. However, we do not support CMS's proposals for any of the measures since we do not support their inclusion in the program at this time.**

Future Measures

While the agency proposes no other specific measures, CMS does invite public comment on measures and measurement topics being considered for future years. Nearly all of the listed measures were included on the MAP's "Measures Under Consideration" list for the LTCHQR program this year. In reviewing these measures, the MAP noted that while many of them address important quality and patient safety topics, none has been fully specified and tested for use in the LTCH setting.²

The AHA agrees with the MAP's assessment of these measures. To the extent that CMS wishes to include these measures in future programs, each measure's specifications must be updated and tested to ensure that they are appropriate for the LTCH setting. **The updated measure specifications must be reviewed and endorsed by the NQF. We also urge CMS to**

² National Quality Forum. *MAP Pre-Rulemaking Report: 2013 Recommendations on Measures under Consideration by HHS*. The report can be accessed at <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=72746>

include any updated and endorsed measures on the MAP's "Measures Under Consideration" list before proposing them for inclusion in the MAP program.

Disaster/Extenuating Circumstances Waiver

The AHA supports CMS's proposed disaster/extenuating circumstances waiver process for the LTCHQR program. We commend the agency for recognizing the impact of natural disasters and other extenuating circumstances on the ability of hospitals to collect and report quality data. Under the proposed process, LTCHs would submit a waiver request to CMS within 30 days of the occurrence of the extraordinary circumstance, providing evidence of the impact of the extraordinary circumstance, and an estimated date when reporting would be able to resume. CMS also proposes that it has the authority to grant waivers or extensions to a region or locale even if hospitals do not specifically request them.

Reconsiderations and Appeals Process

The AHA supports the agency's proposed reconsideration and appeals process for the LTCHQR program. Each year, the agency proposes to notify any LTCHs found to be non-compliant with the LTCHQR program reporting requirements that they may be subject to a reduction in their annual payment update. LTCHs would be given an opportunity to file a reconsideration request with CMS. In the request, LTCHs would need to provide either a justifiable reason for non-compliance, or evidence that the LTCH is actually in compliance. CMS proposes that it could reverse its finding of non-compliance if the hospital provides sufficient evidence that it complied with the requirements, or has a justifiable reason why it could not comply.

Thank you again for the opportunity to comment. If you have any questions, please feel free to contact me or Rochelle Archuleta, senior associate director of policy, at (202) 626-2320 or rarchuleta@aha.org.

Sincerely,

/s/

Rick Pollack
Executive Vice President