



American Hospital
Association

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

June 15, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1632-P
P.O. Box 8013
Baltimore, MD 21244-1850

RE: CMS 1632-P, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates; Revisions of Quality Reporting Requirements for Specific Providers, Including Changes Related to the Electronic Health Record Incentive Program, April 30, 2015.

Dear Mr. Slavitt:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including 286 long-term care hospitals (LTCHs), 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) 2016 proposed rule for the inpatient and LTCH prospective payment systems (PPS). This letter addresses the proposed criteria for the standard LTCH PPS rate, the proposed implementation of LTCH site-neutral payment and the proposed additions to the LTCH quality reporting program (QRP). We will submit comments separately on the agency's inpatient PPS proposals.

In addition to other changes, this rule proposes implementation of the Bipartisan Budget Act of 2013 (BiBA) requirement to add a site-neutral payment component to the LTCH PPS for cost reporting periods beginning on or after Oct. 1, 2015. This change represents a major transformation of the LTCH PPS. **We support many of CMS's proposals, such as how the agency would identify psychiatric and rehabilitation cases and intensive care unit (ICU) or coronary care unit (CCU) days, which align with congressional intent. However, we have serious concerns about others, especially the proposal to use the patient discharge status code from prior hospital stays, to, in part, distinguish cases that would be eligible for a**



standard LTCH PPS payment versus a site-neutral payment. In addition, we have great concern about the proposed policy for site-neutral cases that would receive a high cost outlier payment. We also call for CMS to share its comprehensive plan and timeframe for implementing the numerous new data reporting and other requirements of the IMPACT Act.

PROPOSED CRITERIA FOR STANDARD LTCH PPS RATE

Under BiBA's new dual-rate system for LTCHs, certain qualifying cases will be paid the traditional LTCH PPS rate, while others will be paid a lower site-neutral rate based on an inpatient PPS rate. Specifically, to be eligible for a standard LTCH PPS rate, a case must:

- Not have a principal LTCH diagnosis related to a psychiatric or rehabilitation condition;
- Be "immediately discharged" from an inpatient PPS hospital to an LTCH; and
- Either receive three or more days of care in an ICU or CCU during the prior hospital stay, or be assigned to a qualifying procedure code for 96+ hours of ventilator care in the LTCH.

PSYCHIATRIC AND REHABILITATION CASES

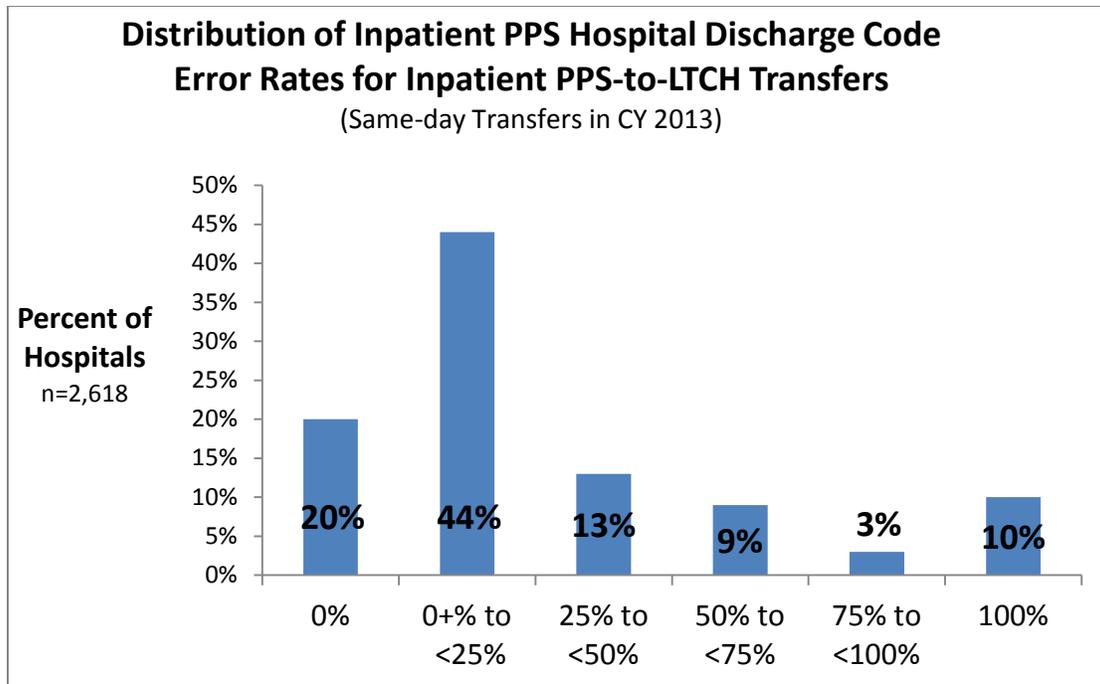
The AHA supports CMS's proposal to use a specific set of 15 Medicare-severity-LTC-diagnosis-related groups (MS-LTC-DRGs) to identify the psychiatric and rehabilitation conditions that would be paid a site-neutral rate. We agree with the agency that these particular codes would carry out BiBA's intent related to this group of cases.

IMMEDIATE DISCHARGES

The AHA opposes the proposed use of inpatient PPS discharge status codes to, in part, identify cases that were immediately discharged from an inpatient PPS hospital to an LTCH, since these codes are highly unreliable and would result in the systematic undercounting of cases eligible for a standard LTCH PPS rate. Specifically, CMS is proposing two criteria that a case must meet to be considered immediately discharged. First, a case must be transferred from an inpatient PPS hospital to an LTCH within one day. Second, the prior inpatient PPS claim must have either discharge status code 63 or 91, which indicates that a patient was discharged to an LTCH. If during this transition, a patient received home care or services in an inpatient rehabilitation, inpatient psychiatric or skilled-nursing facility, the case would be ineligible for a standard LTCH PPS rate.

As noted, inpatient PPS discharge status codes are highly unreliable. **AHA analysis of the 2013 standard analytical file (SAF) data set found that for same-day inpatient PPS-to-LTCH transfers, the inpatient PPS discharge codes were incorrect 15 percent of the time. For inpatient PPS-to-LTCH transfers on the day following inpatient PPS discharge, the discharge code was erroneous 38 percent of the time.** In both cases, the most common error

was that the prior inpatient PPS claim had a discharge status code for a skilled nursing or inpatient rehabilitation facility, instead of an LTCH. We further examined error rates on a hospital-specific basis. The data below demonstrate the magnitude of these error rates across the 2,618 hospitals that reported same-day transfers to an LTCH in calendar year (CY) 2013. Specifically, although the overall error rate is 15 percent, 35 percent of these hospitals had error rates of at least 25 percent.



CMS's stated purpose for requiring discharge codes 63 or 91 is to try to ensure that the transferring patient did not receive another service between inpatient PPS discharge and LTCH admission. However, Dobson-DaVanzo's analysis of cases that transfer to an LTCH (2013 SAF data set) indicates that any such interim services are rare, because 99.4 percent of LTCH admissions occur on the same day as the inpatient PPS discharge. Regarding the remaining 0.6 percent of cases, they are admitted to an LTCH one day following inpatient PPS discharge. We agree with CMS that many of these are cases were likely discharged before midnight, but not officially admitted to the LTCH until just after midnight. **Thus, the agency's concern about other services being provided between inpatient PPS discharge and LTCH admission is unwarranted and should be withdrawn as the rationale for requiring discharge codes 63 and 91. Instead, CMS should use only a single criterion to define an immediate discharge – that a case must be transferred from an inpatient PPS hospital to an LTCH within one day.** If in the future CMS determines that a material percentage of inpatient PPS-to-LTCH transfers are occurring on the day after discharge and non-LTCH services are occurring during this interim, we recommend that the agency study the problem to identify a reliable means to detect such services.

In summary, this inpatient PPS discharge code proposal targets a non-existent problem, is based on an unreliable data metric, and would penalize LTCHs for unintentional data inaccuracy.

ICU/CCU REVENUE CODES

The AHA supports CMS's proposal to include all ICU and CCU revenue codes when identifying cases to be paid a standard LTCH PPS rate. Under the proposed rule, all ICU (020x) and CCU (021x) revenue codes would be used when counting a patient's ICU and CCU days during the prior general acute-care hospital stay. AHA analysis of general acute-care hospital coding practices found that hospitals use a wide array of revenue coding approaches, as allowed under the Medicare guidelines. Specifically, we examined hospitals in the Chicago and Minneapolis areas. In Chicago, 32 percent of ICU days were coded using the general ICU code, while 72 percent of ICU days in Minneapolis were coded using the general ICU code. Substantial variation also was found within marketplaces: seven Chicago hospitals coded zero ICU days with the general ICU code, 18 Chicago hospitals coded 100 percent of its ICU days with the general code, and another Chicago hospital coded 100 percent of their ICU days with the intermediate ICU code. Given this wide variation, CMS was warranted in its decision to include all ICU and CCU codes in its policy proposal.

PROPOSED VENTILATOR CRITERION

While we support CMS's proposal to use ICD-10-PCS procedure code 5A1955Z (Greater than 96 consecutive hours of mechanical ventilator services) to identify LTCH cases that meet the ventilator criterion for a standard LTCH PPS payment, we are concerned that the proposed code would exclude some ventilator cases that should also qualify for a standard LTCH payment under this criterion. Specifically, patients who receive *exactly* 96 hours of ventilator services would not be captured under CMS's proposed ventilator criterion – even though BiBA authorizes their eligibility for a standard LTCH PPS rate. Under ICD-10, cases receiving precisely 96 hours of ventilator services will have a different procedure code, ICD-10-PCS code 5A1945Z (24 – 96 hours of mechanical ventilator services). To address this inappropriate exclusion, we recommend that CMS expand the proposed ventilator criterion to include cases that have either ICD-10-PCS code 5A1955Z or meet *both* of the following criteria:

- ICD-10 code 5A1945Z (Continuous invasive mechanical ventilation, 24 – 96 consecutive hours); and
- One of the following six MS-LTC-DRGs:
 - MS-LTC-DRG 3: ECMO or trach w MV 96+ hrs or PDX exc face, mouth & neck w maj O.R.;
 - MS-LTC-DRG 4: Trach w MV 96+ hrs or PDX exc face, mouth & neck w/o maj O.R.;
 - MS-LTC-DRG 207: Respiratory system diagnosis w ventilator support 96+ hours;
 - MS-LTC-DRG 870: Septicemia or severe sepsis w MV 96+ hours;
 - MS-LTC-DRG 927: Extensive burns or full thickness burns w MV 96+ hrs w skin graft; and

- MS-LTC-DRG 933: Extensive burns or full thickness burns w MV 96+ hrs w/o skin graft.

By cross-referencing these particular MS-LTC-DRGs, which denote (among other conditions) cases with 96 or more hours of mechanical ventilation services, with the ICD-10 code for 24-96 hours of these service, CMS will be able to capture the cases that receive precisely 96 hours of mechanical ventilation services.

PROPOSED HIGH-COST OUTLIER POOL

Under the proposed rule, CMS would implement different high-cost outlier policies for cases paid a standard LTCH PPS rate versus those paid a site-neutral rate. The proposed FY 2016 high-cost outlier pool for standard LTCH PPS rate cases would be calculated using only those FY 2014 cases eligible for the standard rate, be set at 8 percent and result in a proposed fixed-loss amount of \$18,768. CMS's calculations used the 73,427 cases CMS identified as meeting the LTCH criteria. However, the AHA has identified a larger set of standard LTCH PPS cases – 103,143. This substantial difference is due to the rolling cost report start dates during the FY 2016 phase-in of the dual-rate structure, which will result in 29,716 additional cases being paid a standard LTCH PPS rate because, while they technically meet site-neutral payment criteria, they were discharged during the LTCH's prior cost reporting period. **To account for this oversight, we strongly urge CMS to re-calculate the 8 percent high-cost outlier pool and proposed fixed-loss amount using all standard LTCH PPS cases.** We estimate that by using the narrower set of cases, CMS has essentially set this high-cost outlier pool to 7.4 percent, rather than 8.0 percent, and has recommended a fixed-loss amount that is too high. Our analyses indicate that a re-calculated high-cost outlier pool that is set to 8.0 percent would yield a fixed-loss amount of \$15,919.

PROPOSED IMPLEMENTATION OF SITE-NEUTRAL PAYMENTS

Under BiBA, the new two-tiered payment system will be implemented in FY 2016 on a rolling basis, for LTCH cost reporting periods beginning Oct. 1, 2015 and after. For site-neutral cases, CMS proposes a payment rate that is the lower of the inpatient PPS-comparable per-diem amount, including any outlier payments, or 100 percent of the estimated cost of the case, including high-cost outliers. The agency also targets a high-cost outlier (HCO) pool for site-neutral cases that aligns with the inpatient PPS HCO pool of 5.1 percent, and applies the inpatient PPS fixed-loss amount for these cases, which, for FY 2016, is estimated to be \$24,485.

Using information provided by CMS, the AHA estimates that 45 percent of LTCH cases in the FY 2014 claims data, or 60,710 cases, would have received the site-neutral rate. However, during the FY 2016 transition to the two-tiered system, we estimate that only approximately half of these cases will actually receive a site-neutral payment, as LTCH cost report start dates are spread across all 12 months. In addition, in FYs 2016 and 2017, cases paid under the LTCH site-

neutral policy will receive a 50/50 blend of the standard LTCH PPS and site-neutral rates, referred to below as the “standard rate” portion and the “site-neutral” portion, respectively.

CALCULATION OF HIGH-COST OUTLIER POOL

The AHA opposes CMS’s proposal to apply extra budget neutrality adjustments (BNA) to both the site-neutral and standard rate portions of site-neutral payments. CMS estimates that for the FY 2014 cases that would have received a site-neutral payment, HCO payments for the site-neutral portion of the blended payment would be 2.3 percent of total LTCH PPS payments. These cases would be subject to the inpatient PPS fixed-loss amount of \$24,485. **However, we have several concerns related to CMS’s proposed calculation of this 2.3 percent estimate, which are described in further detail in our Technical Appendix. Specifically:**

- **The proposed rule does not clearly outline how CMS calculated the 2.3 percent estimate;**
- **CMS inappropriately applies duplicate outlier-related BNAs to both the standard rate and site-neutral portions of the blended payment; and**
- **CMS inappropriately utilizes both site-neutral and standard rate elements when calculating the site-neutral HCO pool.**

The AHA requests a detailed articulation of the steps used by CMS to calculate the 2.3 percent BNA. The agency’s only reference to the 2.3 percent figure is found on page 24649 of the proposed rule, and it is very brief. However, page 24540 of the proposed rule references a 5.1 percent estimate instead. Specifically, it states:

“For site neutral payment rate cases, we are proposing to use the fixed-loss amount determined annually under the IPPS HCO policy, and we estimate that this would result in an estimated proportion of HCO payments to total LTCH PPS payments for site neutral payment rate cases of 5.1 percent.”

CMS informed us that the 5.1 percent estimate is based on the ratio of the site-neutral portion of HCO payments for site-neutral cases¹ to total payments for site-neutral cases *before* calculating the blend. It also clarified that the 2.3 percent estimate is based on the ratio of the site-neutral portion of HCO payments for site-neutral cases to total payments for site-neutral cases *after* calculating the blend. If this is the case, these estimates are simply different versions of the same calculation. Yet, CMS applied both 5.1 percent and 2.3 percent BNAs to the site-neutral rates. CMS also applied a BNA for the 2.3 percent figure to the standard rates that are used to calculate the blended rate for site-neutral cases, even though this figure is not related to the standard rate at all. **The application of this 2.3 percent BNA is unnecessary and inappropriately lowers LTCH payments.**

¹ That is, HCO payments that were part of *only* the site-neutral portion of the blended payments to site-neutral cases in FY 2016.

We speculate that this inconsistency has arisen due to the complexity of applying the blended rates to FY 2016 payments. CMS's proposed methodology for doing so utilizes discordant concepts related to the 2.3 percent and 5.1 percent targets, which is one of the major hindrances to us understanding the calculations leading to its proposed HCO outlier pool for site-neutral cases. **Therefore, when applying blended payments in FYs 2016 and 2017, we urge CMS to calculate the site-neutral and the standard rate portions separately. That is, we urge CMS to allow the site-neutral portion to be governed solely by the inpatient PPS rates (which have already been adjusted for outlier budget neutrality) and inpatient PPS fixed-loss amount, and allow the standard rate portion to be governed solely by the standard LTCH PPS rates (which also have been adjusted for outlier budget neutrality) and the LTCH PPS fixed-loss amount.** By removing elements of the site-neutral HCO calculation that inappropriately co-mingle site-neutral and standard rate elements, CMS would streamline the policy in a way that will help set accurate payments for both the site-neutral and standard rate portions.

Duplicate BNAs Are Unwarranted and Result in Inappropriately Low-payment Rates. CMS is proposing two outlier-related BNAs for the standard LTCH PPS rates that are used to calculate the blended rate paid to site-neutral cases. The first BNA, which CMS applies to the standard rate, is 8 percent and allocates funds for an 8-percent outlier pool for all standard LTCH PPS cases. The second BNA, which CMS applies to both the site-neutral and standard portion of the blended rate, is 2.3 percent. Thus, for cases paid under the site-neutral blended rate, the standard rate portion of that payment will have two BNAs applied. **Consequently, the standard rate portion of the blended payment is lower than the standard rate used to pay standard LTCH PPS cases. This is inappropriate.**

CMS also proposes two outlier-related BNAs for site-neutral rates. Specifically, the inpatient PPS rates used as the basis for site-neutral payment rates are already subject to a BNA for the inpatient PPS's 5.1 percent outlier pool. However, within the LTCH payment framework, CMS proposes a second BNA of 2.3 percent for the site-neutral outlier pool. CMS's rationale for this second BNA is to ensure that site-neutral HCO payments do not increase aggregate LTCH PPS payments. **However, we strongly disagree that the additional 2.3 percent BNA is necessary to achieve this goal; rather, it was already achieved when the 5.1 percent BNA was applied to the inpatient PPS rates used as the basis for the site-neutral rates. We recommend that CMS calculate standard LTCH PPS and site-neutral rates separately, without any co-mingling of these payments, as mentioned previously.** Furthermore, the second BNA prevents LTCH site-neutral payments from aligning with inpatient PPS payments for associated MS-DRG and MS-LTC-DRGs, which would counter the goals of BiBA.

Duplicative BNA Based on Overstated Costs and Lengths of Stay for Site-neutral Cases. **While we urge CMS to eliminate application of the duplicative 2.3 percent BNA, if it does not, it must at the very least correct its calculation of the figure, which is based on overstated costs and lengths of stay.** Specifically, when calculating the site-neutral rates for FY 2016, CMS used the historical cost and length-of-stay data from the FY 2014 LTCH MedPAR file. However, this approach does not align with the generally held expectation that site-neutral cases will have, on average, lower levels of medical severity and shorter lengths of stay than standard

rate cases. CMS itself notes that it shares this expectation, stating in the proposed rule that its “actuaries project that the costs and resource use for cases paid at the site-neutral payment rate would likely be lower, on average, than the costs and resource use for cases paid at the LTCH PPS standard Federal payment rate, and would likely mirror the costs and resource use for IPPS cases assigned to the same MS-DRG.” **Given this expectation, instead of using historical LTCH costs and lengths of stay as the basis for the site-neutral HCO calculations, the agency should use the inpatient PPS data to try and align the costs and lengths of stay for site-neutral cases with inpatient cases in the same MS-DRGs.** Doing so would produce more accurate payments that align with the expected profile of site-neutral cases. In addition, as discussed further in our Technical Appendix, CMS has used 100 percent of its estimate of the site-neutral portion of the HCO payment to calculate the 2.3 percent estimate when site-neutral cases will only get 50 percent of this amount due to the blend. This also is inaccurate, and the calculation itself is unwarranted.

REGULATORY RELIEF FOR SITE-NEUTRAL CASES

The AHA opposes CMS’s proposal to apply burdensome regulations that were originally designed for traditional LTCH cases to the new category of site-neutral cases. The agency’s proposal to apply both the LTCH interrupted stay and 25% Rule policies to site-neutral cases would fail to treat this new type of LTCH service in a manner that matches Congress’ site-neutral mandate. Under the interrupted stay policy, an LTCH patient experiences a planned, temporary discharge to another setting – most commonly to a general acute-care hospital for a surgery. While subject to a statutory moratorium on full implementation, the 25% Rule imposes a Medicare payment reduction for LTCH transfers from a general acute-care hospital that exceed a specified threshold. **Both of these regulations were designed for the LTCH case-mix that, on average, has a 25+-day average length of stay and is paid a full LTCH PPS rate. We urge CMS to waive the interrupted stay and 25% Rule policies for site-neutral cases.**

CMS’s rationale for applying these policies to site-neutral cases is that the site-neutral rate is an alternative LTCH PPS payment amount, rather than an LTCH PPS exception. However, the LTCH site-neutral service is not merely an alternative. Rather, it is fundamentally distinct from the standard LTCH PPS service line with regard to length of stay, weights, payment amounts, outlier policies, hospital resources and clinical service intensity.

We estimate that site-neutral cases will be paid, on average, \$31,000, or 66 percent, less than the average LTCH PPS case, and are expected to have a dramatically lower average length of stay than that of the LTCH PPS population.² The standard LTCH PPS cases will continue to be subject to the 25+-day average length of stay requirement. Congress acknowledged the

² This calculation used historical LTCH costs and lengths of stay from the FY 2014 *LTCH* MedPAR data. The AHA also calculated this differential using *inpatient* PPS MedPAR data for FY 2014 to calculate payments for site-neutral cases to reflect their anticipated lower costs and lengths of stay, which found site-neutral payments of, on average, \$37,000, or 79 percent, lower than standard LTCH PPS payments. Neither of these calculations accounts for the rolling basis implementation of the site-neutral policy, FY 2016 blended rates, or CMS’s proposed second BNA of 2.3 percent.

uniqueness of the LTCH site-neutral cases by excluding them from the 25+-day average length of stay requirement that will still apply to standard LTCH PPS cases.

Given the misalignment between these regulations and congressional intent for LTCH site-neutral payment, combined with the anticipated volatility in site-neutral case volume, it makes sense to provide regulatory relief for site-neutral cases as LTCHs adapt to the new, more complex payment structure. **As such, we encourage CMS to pair site-neutral payment with site-neutral regulation by waiving both the interrupted stay and 25% Rule policies for LTCH site-neutral cases.**

TIMING CONCERNS

AHA members have raised several concerns regarding the dependence of LTCH payment on information from the prior inpatient PPS hospital stay. First, at the point of admission, LTCHs often will not have access to either information on the number of ICU/CCU days a patient received in the prior stay or the inpatient PPS discharge status code. This will place LTCHs in a vulnerable situation as they attempt to determine whether the patient should be considered a standard LTCH PPS versus site-neutral case. Should LTCHs admit an expected standard LTCH PPS patient who is ultimately categorized as a site-neutral case, this would have significant ramifications for payment and the effort to manage the discharge ratio.

LTCHs that bill Medicare soon after a patient is discharged also may face timing challenges if the referring inpatient PPS hospital does not also bill Medicare quickly. Our members report that some inpatient PPS hospitals exercise the full 180-day billing window allowed under Medicare timely filing guidelines. In such cases, the LTCH's payment would presumably be placed on hold until the referral hospital's claim is submitted, since LTCH payment is determined, in part, by the occurrence of an immediate discharge from the prior inpatient PPS hospital, ICU/CCU days in the prior hospital, and, as currently proposed, the discharge status code.

This uncertainty, the substantial length of time that may be required to confirm these data and the magnitude of the payment differential, will place LTCHs in a highly precarious situation. **We urge CMS to give careful consideration to policy remedies that will 1) enable LTCHs to access key data from the referral hospital in a timely fashion; and 2) facilitate timely payment of LTCHs.**

LTCH DISCHARGE RATIO REQUIREMENT

As required by BiBA, in FY 2016, CMS proposes to begin reporting the portion of each LTCH's cases that are site-neutral cases. Beginning with FY 2020 cost-reporting periods, if site-neutral cases exceed 50 percent of total discharges, an LTCH will be fully paid as a general acute-care hospital under the inpatient PPS for the subsequent cost-reporting period. CMS stated that it will be issuing sub-regulatory details on this requirement in the future. We ask CMS to include in these pending details a remediation policy for any LTCHs that fall into noncompliance with this policy.

PROPOSED CHANGES TO THE LTCH QRP

For the FY 2018 LTCH QRP, CMS proposes to use three previously adopted measures to satisfy the requirements of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. The IMPACT Act is intended to foster greater standardization and alignment of measures across CMS's post-acute care quality reporting programs, including the LTCH QRP. CMS also re-proposes its previously finalized all-cause readmission measure so it reflects the version of the measure recently endorsed by the National Quality Forum (NQF).

We first offer general comments on CMS's implementation approach for the IMPACT Act, then address CMS's specific proposals.

GENERAL CONSIDERATIONS FOR IMPLEMENTING THE IMPACT ACT

The AHA strongly encourages CMS to develop and make publicly available a comprehensive plan describing how it will implement the provisions of the IMPACT Act in all of its post-acute care quality programs. The IMPACT Act is a multi-faceted law that will have significant operational impacts for LTCHs, inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs) and home health agencies. The law's requirements will involve changes to quality measures and the patient assessment tools used for each setting. A comprehensive plan would enable all stakeholders to understand whether CMS's approach works in a concerted fashion across its programs. It also would give all of the affected post-acute care providers an opportunity to plan for the potential impacts to their operations.

The AHA asks that CMS adhere to the four principles outlined below in implementing the provisions of the IMPACT Act:

- *Communicate estimated implementation timelines for all data collection and reporting requirements as early as possible.* We appreciate that CMS used the proposed rule to indicate that IMPACT Act quality measure requirements would generally be tied to payment in the fiscal year that begins two years after they are adopted in rulemaking. We encourage the agency to use its plan to identify the estimated implementation dates for specific measures and patient assessment data.
- *Use reliable, accurate, feasible and care-setting appropriate measures that are both endorsed by the NQF, and reviewed by the multi-stakeholder Measure Applications Partnership (MAP).* The IMPACT Act strongly encourages the use of NQF-endorsed measures as well as the MAP review process. We applaud CMS for engaging the MAP in an *ad hoc* review earlier this year. However, as described in greater detail below, we are concerned that two of the proposed measures for FY 2018 lack NQF endorsement.
- *Foster as much standardization of measures and data collection across post-acute care settings as possible, while recognizing that limited variations may still be necessary.* The IMPACT Act requires that CMS adopt the same measurement domains for all post-acute

care quality reporting programs, and that the measures be “standardized and interoperable” across post-acute care facilities. However, the statute does not provide specific operational definitions of these two terms. We believe how CMS interprets these terms will have significant implications for post-acute providers.

The AHA cautions that “complete” standardization and interoperability of measures – i.e., using the exact same measure specifications, data definitions and data collection tools across all post-acute settings – may not always be possible. The agency may not have NQF-endorsed measures shown to work across all four settings. Similarly, CMS may need to alter measures so they work with the data collection mechanisms of a particular care setting, or so that they focus on collecting the data most relevant to a particular patient population. In such instances, CMS could instead focus on achieving “topical” standardization in which all four post-acute care provider types report on the same measure topics, but using data collection instruments and definitions (e.g., rating scales) that may vary. To fulfill the requirement of “interoperability,” CMS could develop mechanisms to ensure the data are routinely shared across post-acute settings with crosswalks or other explanations of how the data from each setting are defined. In those instances where the agency can only achieve “topical” standardization, CMS should undertake additional measurement development activities to determine whether greater standardization is possible.

- *Minimize the burden of collection and reporting requirements.* LTCHs and other post-acute care providers must balance numerous reporting requirements from CMS, private payers and others. CMS should ensure any new requirements add value and are not unnecessarily duplicative with existing reporting requirements.

FY 2018 MEASUREMENT PROPOSALS

The IMPACT Act mandates that CMS adopt measures addressing several measure “domains” for all of its post-acute care quality reporting programs. To address the domains of skin integrity, major falls and functional status, CMS proposes to use the three previously adopted measures LTCH QRP measures; we comment on each proposal below.

Pressure Ulcers. The AHA supports CMS’s proposal to use the previously finalized pressure ulcer measure to meet IMPACT Act requirements. The measure assesses the percentage of patients with stage 2 to 4 pressure ulcers that are new or worsened since admission to the LTCH. This measure is NQF-endorsed, and has been collected in the LTCH QRP since the program’s inception. The MAP also supported the use of this measure in the LTCH QRP to meet IMPACT Act requirements.

Major Falls. While the AHA appreciates that CMS intends to adopt the falls measure already in use in the LTCH QRP to meet IMPACT Act requirements, we continue to urge the agency to seek and obtain NQF endorsement of the measure for use in LTCHs. The measure assesses the percentage of patients that experience one or more falls with major injury.

While the measure is NQF-endorsed, the measure specifications and testing data used to obtain NQF endorsement are specific to nursing homes. As a result, it is not specifically endorsed for use in LTCHs. Nevertheless, CMS proposes to continue using this measure because the agency believes it meets the IMPACT Act's requirement that measures be "interoperable" across care settings.

We also urge CMS to incorporate risk adjustment into the measure. A patient's propensity for falls is determined by not only the quality of care, but also a variety of other clinical factors beyond the control of providers, including co-morbid conditions, baseline level of functioning and so forth. Furthermore, the IMPACT Act requires that measures include risk adjustment where necessary and appropriate. In the context of quality measurement, risk adjustment is a widely accepted approach to account for some of the factors outside the control of providers when one is seeking to isolate and compare the quality of care provided by various entities. Risk adjustment is meant to create a "level playing field" that allows fairer comparisons of whether providers are doing all they can to ensure the quality of care.

Functional Status. The AHA continues to urge CMS to improve the reliability and accuracy of the LTCH QRP functional status measure before implementing it in the program. The measure assesses the percentage of LTCH patients who have functional status assessments completed at both admission and discharge and who have a care plan that addresses function. CMS would collect the measure using a version of the LTCH CARE Data Set modified to collect the needed measure data. At the times of admission and discharge, trained clinicians would be required to numerically score the level of independence that patients demonstrate on several assessment items, including self-care, mobility, cognition, communication and bladder continence. The LTCH CARE Data Set items would include a six-level rating scale. Additionally, LTCH clinicians will be required to record a numerical functional goal score at admission for at least one of the assessment items. LTCHs would be measured on the proportion of their patients with complete assessment data, and not on the actual changes in functional status scores between admission and discharge

The AHA disagrees with CMS's decision to finalize this measure in last year's rule. We remain concerned this measure lacks NQF endorsement, has reliability problems and is burdensome to collect. Evidence from the August 2012 final report on the development of the CARE tool indicates there is significant room to improve the reliability of the measures when used in LTCHs.³ One gauge of reliability is "inter-rater reliability," which assesses whether two people collecting the same measure obtain the same measure results. This test of reliability is especially appropriate for the functional status measures because it relies on data collection by multiple clinicians. The level of agreement between the raters can be quantified using a Kappa statistic that has a result between 0 and 1; the higher the Kappa statistic, the better the agreement between raters. The 2012 CARE tool final report indicates that "LTCHs appear to have slightly lower [Kappa] rates of items than other settings." Additionally, several specific self-care and

³ See RTI International, *The Development and Testing of the Continuity Assessment Record and Evaluation (CARE) Item Set: Final Report*. August 2012. All three volumes of the report are available at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/CARE-Item-Set-and-B-CARE.html>.

mobility items have Kappa statistics that categorize inter-rater reliability as only fair (Kappas of between 0.21 and 0.40) or moderate (0.41 to 0.60). These items include eating (0.446), oral hygiene (0.331), toilet hygiene (0.339), lower body dressing (0.447), sit to stand (0.551), and chair/bed to chair transfers (0.556). We also note that these testing results are based on an ineffective sample size of only 46 LTCH patient records.⁴

These levels of reliability are insufficient for a national quality reporting program. Fair or moderate reliability may be acceptable for exploratory studies or internal improvement efforts. However, CMS would implement these measures on a national scale across most post-acute care providers. In addition, the collection and reporting of these measures would require substantial resources. In order for such an investment of resources to return value to providers seeking to benchmark their quality improvement efforts, and to consumers seeking to understand the quality of care in LTCHs, it is essential that the measure yield accurate results. The available evidence suggests these measures, as currently constructed, fall well short of that standard.

Readmissions Measure. The AHA appreciates that CMS proposes to adopt the NQF-endorsed version of its previously finalized readmission measure. However, we strongly urge the agency incorporate sociodemographic adjustment into the measure before implementing it. The measure assesses the rate of readmissions to short-term acute care hospitals and LTCHs within 30 days of discharge from an LTCH. The measure is calculated using Medicare fee-for-service claims data, and captures returns of Medicare patients within 30 days of LTCH discharge from the community or another care setting of lesser intensity (e.g., SNFs, home health, IRFs) to an acute care hospital or LTCH. It excludes transfers from an LTCH to either another LTCH or to an acute care hospital. The measure also excludes certain procedures and diagnoses where readmissions are generally considered “planned” events (e.g., chemotherapy, labor/delivery, transplantation, amputations, removal of feeding and tracheostomy tubes, and some colorectal procedures).

Unfortunately, the measure fails to recognize the substantial research showing that community factors outside the control of the hospital – such as the availability of primary care, mental health services, easy access to medications and appropriate food – significantly influence the likelihood of a patient’s health improving after discharge from an LTCH or whether a readmission may be necessary. These community issues are reflected in readily available proxy data on sociodemographic status, such as census-derived data on income and education level, and claims-derived data on the proportion of patients dually eligible for Medicare and Medicaid. We urge CMS to use these data to apply sociodemographic adjustment to the LTCH readmission measure.

DATA SUBMISSION REQUIREMENTS

The AHA supports CMS’s proposed changes to the data submission timeframes for LTCH QRP measures. Specifically, the agency proposes that LTCHs will have 4.5 months

⁴ See RTI International, *The Development and Testing of the Continuity Assessment Record and Evaluation (CARE) Item Set: Final Report on Reliability Testing, Volume 2 of 3*. August 2012. Referenced numbers are on the table on pp. 45-46.

(approximately 135 days) from the end of a calendar year quarter to submit required data, instead of the current 45 days. The proposal would take effect with data submitted for the fourth quarter of CY 2015 to meet FY 2017 LTCH QRP reporting requirements, and continue into FY 2018 and beyond. CMS suggests would “align data submission and correction deadlines” with other quality reporting programs, thereby facilitating public reporting.

LTCH QRP PUBLIC REPORTING

The AHA supports CMS’s proposal to publicly report LTCH QRP data beginning in the fall of 2016, and applauds the agency’s intent to give LTCHs a 30-day period to preview their data. However, we strongly urge CMS to allow LTCHs to submit data corrections during this preview period. CMS proposes to report data on catheter-associated urinary tract infections (CAUTI), central-line associated blood stream infections (CLABSI), pressure ulcers and readmissions. Similar to other CMS quality reporting programs, the agency proposes to give LTCHs a 30-day period to preview their performance. However, this 30-day period would not provide an opportunity to submit corrections to the data. Instead, CMS states that its proposal to extend the data submission period for LTCH data will give LTCHs sufficient opportunity to review and submit corrections to their data.

However, with nearly all of its other quality reporting programs, CMS allows providers to submit data corrections in conjunction with the data preview period. This is appropriate because the process of collecting and reporting quality measure data is time and resource intensive. It also allows providers and CMS to catch and address any inadvertent data processing errors between the time data are transmitted to the agency and when the data are reported publicly.

OTHER CONCERNS

REQUEST FOR ADDITIONAL DATA

The AHA urges CMS to release additional data that will enable the AHA and other stakeholders to conduct a full analysis of CMS’s LTCH proposals in the rule. We appreciate that CMS added a flag to the LTCH MedPAR data that identifies whether a patient will be paid at the standard payment rate or at the site-neutral payment rate. However, more information is needed to enable the field to fully replicate the proposed policies, including verifying the accuracy of CMS’s payment flag.

In particular, we request that CMS:

- **Add encrypted beneficiary ID and admission and discharge dates to both the national and LTCH MedPAR data sets.** These data are necessary to ascertain which cases were immediately discharged from an inpatient PPS hospital. While CMS does release these data for a prior time period (via the SAF file data set), the data must be present in the MedPAR

data sets that are used for rulemaking, especially as we attempt to study changes in volume, referral patterns and other developments related to site-neutral payment.

Since there are LTCH patients who also could be discharged from inpatient PPS to an LTCH in one year but not discharged from the LTCH until the subsequent year, we request that CMS make available at least two years of national MedPAR data with the encrypted beneficiary ID and admission and discharge dates, so that we can match patients with the previous years' inpatient PPS discharge.

- **Add a variable indicating the number of ICU days in the prior inpatient PPS hospital stay to the LTCH MedPAR.** For those LTCHs that lack the ability to acquire and analyze large Medicare data sets, this would help determine which criteria were used to qualify for site-neutral payment, in addition to other analyses.

TECHNICAL CLARIFICATION REGARDING “CANCER LTCH”

The BiBA granted CMS the authority to pay the single cancer LTCH using a methodology similar to the cost-based rates paid under the Tax Equity and Fiscal Responsibility Act (TEFRA), which were in effect prior to the implementation of the LTCH PPS in FY 2003. As such, since its cost report beginning on or after Oct. 1, 2014, this LTCH has been paid a TEFRA-like, cost-based reimbursement for both operating and capital-related costs. **The AHA continues to support treating this LTCH using the same payment protocols and annual market basket updates that apply to other TEFRA hospitals, including the proposed 2.7 percent market basket update for FY 2016. We encourage CMS to make all technical modifications to the payment regulations needed to facilitate such treatment.**

Thank you for the opportunity to comment on the agency's LTCH proposals for FY 2016. If you have any questions about our comments, feel free to contact me or Rochelle Archuleta, director of policy, at (202) 626-2320 or rarchuleta@aha.org.

Sincerely,

/s/

Rick Pollack
Executive Vice President

**AHA Analyses of CMS’s Proposal for
 Multiple Budget Neutrality Adjustments**

As discussed in our detailed comments, the AHA opposes CMS’s proposal to apply extra budget neutrality adjustments (BNA) to both the site-neutral and standard rate portions of site-neutral payments. Doing so results in inaccurately low payments for these cases. This appendix expands upon these concerns and presents further analyses related to this problem.

Unclear Application of Site-neutral Outlier Pool. As noted in our letter, the proposed rule does not provide sufficient detail on how CMS calculated the 2.3 percent high-cost outlier (HCO) estimate for site-neutral payments. To better understand CMS’s approach for this estimate, the AHA reached out to CMS to confirm details related to its calculations, and we appreciate the agency’s willingness to provide clarifications. Using this information, the AHA attempted to replicate CMS’s estimate of the 2.3 percent outlier percentage, as outlined in the table and bullets below.

AHA Replication of CMS's 2.3% Outlier Estimate for Site-Neutral Cases	
1. Site-neutral Payments Without HCOs	\$315,911,231
2. Site-Neutral Payments With HCOs (line 1 / 0.949)	\$332,888,547
3. Site-Neutral HCO Payments (line 2 minus line 1)	\$16,977,316
4. Total Standard LTCH PPS payments	\$1,111,097,544
5. Blended Payments for Site-Neutral Cases (50% of line 2 + 50% of line 4)	\$721,993,045
6. Site-Neutral Outliers as a Percent of Total LTCH PPS Payments = line 3 / line 5	2.35%

These calculations apply FY 2016 rates to FY 2014 claims data, for only the site-neutral cases that would actually be eligible for a blended rate.

- **Line 1:** This is AHA’s estimate of the site-neutral portion of blended payments, without HCOs. **As described below we have several concerns about CMS using this amount in its calculations, one of them being circularity; the other being that historical costs and lengths of stay are being used for these calculations and are much higher than what CMS’s actuaries expect costs and lengths of stay to be in the future.**
- **Line 2:** This is line 1 divided by 94.9 percent, which adds in the 5.1 percent HCO pool. Thus, this line represents total site-neutral payments, including the 5.1 percent HCO pool, *before* the blend. Page 24540 of the proposed rule references this 5.1 percent outlier pool, stating that “[f]or site neutral payment rate cases, we are proposing to use the fixed-loss amount determined annually under the IPPS HCO policy, and we estimate that this would result in an estimated proportion of HCO payments to total LTCH PPS payments for site neutral payment rate cases of 5.1 percent.” The rule is unclear as to whether the 5.1

percent applies to the site-neutral portion only or the blend but CMS confirmed that it applies to only the site-neutral portion.

- Line 3: The estimated site-neutral outlier payments are calculated by subtracting line 1 from line 2. **Once again, this raises several concerns, one of them being circularity.**
- Line 4: This is AHA's estimate of the amount site-neutral cases would have been paid if they were paid at the standard rate. These payments will be used to calculate the blended rate, and include outlier payments. **CMS also uses higher costs and lengths of stay in these calculations resulting in incorrect estimates.**
- Line 5: Blended payments for site-neutral cases are 50 percent of total site-neutral payments plus 50 percent of total standard LTCH payments.
- Line 6: We believe CMS then divided line 3, estimated *site-neutral* HCO payments, by line 5, total *blended* payments, which produced its estimate that site-neutral HCO payments would be approximately 2.3 percent of *total* LTCH PPS site-neutral payments. **CMS should not be co-mingling the site-neutral and standard rate portions of the blend for purposes of outlier budget neutrality.**

Since the 5.1 percent pool is applied to *only* the site-neutral portion of blended HCO payments and blended total payments, CMS has inflated the amount in line 1 in order to estimate the site-neutral outlier payments. This is not appropriate – the site-neutral cases will only receive 50 percent of total site-neutral payments because of the blend. Instead, the estimate of site-neutral HCO payments should be 50 percent of the \$17 million in line 3 and not the whole amount, and the estimate on line 6 should also be one-half of what it is. Also, since CMS already expects site-neutral HCO payments to be 5.1 percent of total payments *only* in the site-neutral portion, there is no need to then estimate what percent of total *blended* payments this HCO amount is by dividing the *site-neutral* HCO payment by total *blended* payments. In doing so, CMS is using misaligned components in the calculation by first using inpatient PPS rates and an inpatient PPS fixed-loss amount to calculate the site-neutral payments, but then incorporating blended rates that, in part, are based on standard LTCH PPS rates. **This calculation is not accurate and the AHA strongly discourages use of this calculation to avoid site-neutral payment policy that, in part, utilizes standard LTCH PPS rates.**

Another concern with the calculations of the amount noted in line 1 of the table is the circular methodology used to isolate the site-neutral portion of the blend (without HCO payments). This first requires an estimate of the total inpatient PPS comparable amount, which includes an HCO payment, which is then compared to the cost of the case. This calculation uses faulty, circular logic because in essence CMS has already estimated HCO payments for the site-neutral portion to calculate the amount in line 1 and then uses line 1 to re-estimate a different aggregate amount for HCO payments.

Duplicate BNAs. This section expands upon the concern raised in AHA's comment letter that CMS is proposing a duplicative second BNA for both standard LTCH PPS and site-neutral cases. It is not clear what CMS considers to be the baseline aggregate LTCH PPS payments to the site-neutral cases, which it wants to avoid being increased due to HCO payments to the site-neutral cases. Furthermore because of the blend, we are concerned that CMS is incorrectly applying the

second BNA based on mixing payments in the two distinct tiers of the dual-rate payment structure. We estimated what site-neutral payments would be *absent* outlier payments, and compared them to what site-neutral payments should be *with* a 5.1 percent outlier pool, which shows these payment amounts to be approximately the same. This makes it clear to us that the additional BNA is being applied erroneously. This is described below.

Proposed Rule Overstates Cost of Site-neutral Cases. When calculating both standard LTCH PPS and site-neutral payments for site-neutral cases for FY 2016, CMS used cost data that overstated the lower costs that are anticipated for site-neutral cases. Specifically, many expect that site-neutral cases will, on average, have lower levels of medical severity and shorter lengths of stay than those cases that will be paid a standard LTCH PPS rate. CMS agrees, and notes in the proposed rule that its “actuaries project that the costs and resource use for cases paid at the site-neutral payment rate would likely be lower, on average, than the costs and resource use for cases paid at the LTCH PPS standard Federal payment rate, and would likely mirror the costs and resource use for IPPS cases assigned to the same MS-DRG.” Yet, when we examined the historical costs and length of stay for site-neutral cases in the FY 2014 LTCH MedPAR file used by CMS to estimate the amounts in the table above, and compared them with those for cases in the FY 2014 national inpatient PPS MedPAR file, we found that site-neutral LTCH costs were on average almost two-and-a-half times higher than average inpatient PPS costs. We also found that site-neutral LTCH lengths of stay were on average more than five times higher than the inpatient PPS average length of stay. Given CMS’s anticipation of lower costs and lengths of stay for site-neutral cases, we did not use the historical costs and lengths of stay in the FY 2014 LTCH MedPAR data set in our model. Instead, we used the FY 2014 inpatient PPS MedPAR data to attempt to align inpatient PPS costs and lengths of stay with the historical costs and lengths of stay faced by the site-neutral LTCH cases, for corresponding DRGs.

Our Model. The true test of whether LTCH payments to the site-neutral cases would increase because of HCO payments is to examine only the site-neutral portion of the blend which is subject to the 5.1 percent outlier pool and calculate payments with and without outliers. Using the proposed FY 2016 inpatient PPS rates as well as the proposed inpatient PPS fixed-loss amount of \$24,485, we estimated HCO payments to site-neutral cases equal to be 5 percent of total site-neutral payments to these cases, which matches the 5.1 percent outlier pool target. We then re-constructed the calculation without outlier payments, and restored the 5.1 percent BNA to the inpatient PPS rates. These two sets of payments were compared, and found to be very similar. **This similarity between inpatient PPS rates adjusted with the 5.1 percent BNA and with HCO payments, and inpatient PPS rates lacking BNA and without HCO payments indicates that CMS’s concern for a second BNA is unwarranted. Therefore, a second BNA to prevent an increase in overall LTCH PPS payments is not needed.**

As stated in our comment letter, we recommend that CMS not apply the duplicate outlier BNA of 2.3 percent. In addition, CMS should alter its model to avoid mixing the standard and site-neutral payment structures when calculating budget neutrality for the two distinct tiers of the dual-rate structure.