American Hospital Association

Regulatory Advisory

August 25, 2015

LONG-TERM CARE HOSPITAL PPS: THE FINAL RULE FOR FY 2016

AT A GLANCE

The Issue:

On Aug. 17, the Centers for Medicare & Medicaid Services (CMS) published its fiscal year (FY) 2016 final rule for the inpatient and long-term care hospital (LTCH) prospective payment systems (PPS). This advisory covers the rule's LTCH-related provisions. An AHA Regulatory Advisory on the inpatient PPS provisions will be sent to members separately. In addition to the annual payment update for the LTCH PPS rates, this rule implements the Bipartisan Budget Act's (BiBA) requirement to implement site-neutral payments for certain LTCH cases that, in general, have lower medical acuity. This change will take effect on a rolling basis, based on LTCH cost reporting period start dates, beginning on Oct. 1, 2015. Specifically, under the new dual-rate system, certain qualifying cases will be paid the traditional LTCH PPS rate, while others will be paid a lower site-neutral rate that will be based on an inpatient PPS rate. For cost reporting periods beginning in FYs 2016 and 2017, site-neutral cases will be paid a 50-50 blend of the standard LTCH PPS rate and the applicable site-neutral rate. Following this transition period, site-neutral cases will be paid fully site-neutral rates. The rule also substantially changes the LTCH Quality Reporting Program (QRP).

CMS estimates that for FY 2016, when combining the impact of the LTCH PPS payment update (1.5 percent increase) with the impact of adding the site-neutral payment component (14.8 percent decrease), LTCHs will face a net decrease of 4.6 percent, or $250 million, from FY 2015 levels.

Our Take:

The addition of site-neutral payment to the LTCH PPS is a major transformation for the field. We are pleased that the final rule incorporates several significant improvements sought by the AHA, such as eliminating the use of inpatient PPS discharge status codes to, in part, identify patients eligible for the standard LTCH payment, and an improved fixed-loss amount for standard LTCH cases. However, we remain troubled by the finalization of the proposed, duplicative budget neutrality adjustments (BNA) for site-neutral cases receiving a high-cost outlier payment. We are evaluating its impact and accuracy, and will work with members this fall to identify next steps.

What You Can Do:

- ✓ Share the attached summary with your senior management team to examine the affect these payment changes will have on your organization for FY 2016.
- ✓ Look for your LTCH-specific impact estimate from the AHA, which will follow in the weeks ahead.

Further Questions:

For questions on the final rule payment provisions, contact Rochelle Archuleta, director of policy, rarchuleta@aha.org. For quality-related questions, contact Akin Demehin, senior associate director of policy, at ademehin@aha.org.

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BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) published its fiscal year (FY) 2016 final rule for the hospital inpatient and long-term care hospital (LTCH) prospective payment systems (PPS) in the Aug. 17 Federal Register. This advisory covers the rule's LTCH-related proposals. A Regulatory Advisory summarizing the inpatient PPS provisions is forthcoming.

In addition to other changes, this rule implements 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. We are pleased that the final rule incorporates several significant improvements sought by the AHA, such as eliminating the use of inpatient PPS discharge status codes to, in part, identify patients eligible for the standard LTCH payment, and an improved fixed-loss amount for standard LTCH cases. However, we remain very troubled by the finalization of the proposed, duplicative budget neutrality adjustments (BNA) for site-neutral cases receiving a high-cost outlier payment. We are evaluating its impact and accuracy, as well as next steps.

CMS estimates that for FY 2016, when combining the impact of the LTCH PPS payment update (1.5 percent increase) with the impact of adding the site-neutral payment component (14.8 percent decrease), LTCHs will face a net decrease of 4.6 percent, a reduction of $250 million from FY 2015 levels.

FY 2016 PAYMENT UPDATE AND CRITERIA FOR STANDARD LTCH PPS RATE

As required by BiBA, this rule transitions LTCHs to a dual-rate structure that pays for services using two sets of rates – standard LTCH PPS rates and lower, site-neutral rates. This section of the advisory reviews CMS's final methodology for updating the standard LTCH PPS rates and adding new BiBA-required criteria to qualify for these rates.

FY 2016 Standard LTCH PPS Rate

For FY 2016, CMS applies a market-basket update of 2.4 percent, which is based on the LTCH-specific market basket implemented in FY 2013. The market basket will be reduced by two cuts mandated by the Affordable Care Act: a 0.5 percentage point

reduction for productivity and an additional 0.2 percentage point reduction, plus further reductions. As a result, the final FY 2016 standard rate for LTCHs reporting required quality data is $41,762.85, compared to $41,043.71 for FY 2015.

Criteria to Identify Standard LTCH PPS Cases

Under BiBA, 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 a general acute-care hospital to an LTCH; and
- Either receive three or more days of care in an intensive care unit (ICU) or coronary care unit (CCU) during the prior hospital stay, or be assigned to a qualifying procedure code for 96+ hours of ventilator care in the LTCH.

The final rule implements these criteria to identify cases to be paid a standard LTCH PPS rate:

- Psychiatric and Rehabilitation Cases. Without change, CMS finalized that cases with the following 15 Medicare-severity-LTC-diagnosis-related groups (MS-LTC-DRGs) for psychiatric and rehabilitation conditions *would not* be paid a standard LTCH PPS rate, but would instead be paid a site-neutral rate:

    1. MS-LTC-DRG 876 (O.R. Procedure with Principal Diagnoses of Mental Illness);
    2. MS-LTC-DRG 880 (Acute Adjustment Reaction & Psychosocial Dysfunction);
    3. MS-LTC-DRG 881 (Depressive Neuroses);
    4. MS-LTC-DRG 882 (Neuroses Except Depressive);
    5. MS-LTC-DRG 883 (Disorders of Personality & Impulse Control);
    6. MS-LTC-DRG 884 (Organic Disturbances & Mental Retardation);
    7. MS-LTC-DRG 885 (Psychoses);
    8. MS-LTC-DRG 886 (Behavioral & Developmental Disorders);
    9. MS-LTC-DRG 887 (Other Mental Disorder Diagnoses);
    10. MS-LTC-DRG 894 (Alcohol/Drug Abuse or Dependence, Left AMA);
    11. MS-LTC-DRG 895 (Alcohol/Drug Abuse or Dependence, with Rehabilitation Therapy);
    12. MS-LTC-DRG 896 (Alcohol/Drug Abuse or Dependence, without Rehabilitation Therapy with MCC);
    13. MS-LTC-DRG 897 (Alcohol/Drug Abuse or Dependence, without Rehabilitation Therapy without MCC);
    14. MS-LTC-DRG 945 (Rehabilitation with CC/MCC); and
    15. MS-LTC-DRG 946 (Rehabilitation without CC/MCC).

- Immediate Discharge. The AHA is pleased that CMS withdrew the proposed requirement that to be considered "immediately discharged," the Medicare claim for the prior hospital stay must have a discharge status code 63 or 91, which indicates a transfer to an LTCH. Rather, under the final policy, CMS will use only the prior hospital discharge date and the LTCH admission date to identify "immediately discharged" cases that transfer to an LTCH within one day. This improvement over the proposed rule aligns with AHA analysis indicating that

these discharge codes have unacceptably high error rates and, therefore, would be an inappropriate basis for upon which to base payment rates.

In addition, the rule notes that an "LTCH interrupted stay" – a planned, temporary transition from an LTCH to a general acute-care hospital (which most typically occurs for a surgery) – will not invalidate an LTCH case that is otherwise considered to have been "immediately discharged" from a general acute-care hospital to an LTCH.

- ICU/CCU Revenue Codes. As urged by the AHA, CMS will use the full set of ICU (020x) and CCU (021x) revenue codes 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 coding approaches, as allowed under the Medicare guidelines. As a result of this variation, we had encouraged the agency to use all codes when assessing eligibility for a standard LTCH PPS rate.

  In addition, the final rule clarifies that for LTCH patients experiencing an interrupted stay that that includes ICU or CCU days in an inpatient PPS hospital, those days will not be included in the count of ICU/CCU days for purposes of determining LTCH PPS versus site-neutral payment status.

  Finally, in response to concerns that LTCHs, during the initial patient screening process, will often lack access to revenue code information for the prior hospital stay, CMS notes that it encourages inpatient PPS hospitals and LTCHs to communicate and exchange this information, and for LTCHs to ask the referring hospital for this information prior to patient admission.

- Ventilator Criterion. CMS finalized its proposal to use only ICD-10 code 5A1955Z to identify patients who received greater than 96 consecutive hours of respiratory ventilation in an LTCH. CMS notes that it selected this procedure code, rather than using MS-LTC-DRGs, to better capture the population of LTCH cases receiving 96+ hours of ventilator services. However, despite advocacy by the AHA, the final policy continues to exclude cases that receive exactly 96 hours of ventilator services in an LTCH. CMS believes that cases receiving exactly 96 hour of ventilator services are rare, but should they arise, the agency encourages LTCHs to contact their Medicare Administrative Contractors (MACs) for assistance in acquiring a payment adjustment up to the standard LTCH PPS rate.

MS-LTC-DRG Weights

As proposed, to establish the FY 2016 relative weights for standard LTCH PPS rates, CMS will use only those cases in the FY 2014 MedPAR file that would have qualified for the standard LTCH PPS rate. CMS will exclude from these calculations all site-neutral cases. The rule's online addendum lists the final MS-LTC-DRGs and their respective relative weights, average length-of-stay (ALOS) and geometric mean length-of-stay (used to identify short-stay outliers). In keeping with the prior re-weighting approach, the 251 "low-volume MS-LTC-DRGs" (those with fewer than 25 LTCH cases) for FY 2016 will be grouped into quintiles, with each quintile assigned a relative weight. The "no-

volume MS-LTC-DRGs" will again be weighted based on other MS-LTC-DRGs that are clinically similar and have similar costliness. We note that under the new dual-rate structure, the number of no-volume MS-LTC-DRGs will substantially increase: from 247 in FY 2015 to 342 in FY 2016.

Labor-related Share

The labor-related share is the portion of total LTCH costs that are related to, influenced by, or vary with the local labor market, such as wages, salaries and benefits. The final FY 2016 labor-related share is 62.0 percent, which is lower than the FY 2015 labor-related share of 62.306 percent. The labor-related share is implemented in a budget-neutral manner to avoid any change to aggregate LTCH PPS payments.

Area Wage Index

The LTCH PPS wage index is computed using wage data from general acute-care hospitals, without adjustments for geographic reclassification. For FY 2016, CMS will continue to use the updated labor market boundaries that were implemented in FY 2015 and are based on 2010 census data. Those LTCHs that were subject to a FY 2015 blended wage index because they would have otherwise faced a lower wage index due to the new boundaries will fully transition to their new wage index in FY 2016. CMS implements wage index updates for LTCHs in a budget-neutral fashion, "in order to mitigate estimated yearly fluctuations in estimated aggregate LTCH PPS payments." For FY 2016, CMS will apply an area wage index budget-neutrality factor of 1.000513. The FY 2016 wage index values also are provided on CMS's webpage that supplements this rule.

Adjustment for High-cost Outliers

Under the new dual-rate payment system for LTCHs, CMS is implementing separate high-cost outlier policies for standard LTCH PPS cases and site-neutral cases. For cases paid the standard LTCH PPS rate, CMS will continue to target an 8-percent high-cost outlier pool. The fixed-loss amount for this pool will be calculated using only the FY 2014 MedPAR cases that would have been paid the standard LTCH PPS rate. The AHA and other stakeholders advocated that this calculation should have incorporated all LTCH cases, since all cases that year will be paid a standard LTCH rate, either in full or in part, due to the site-neutral blend. However, CMS disagreed and did not make this change. CMS will make no other modifications to its LTCH high-cost outlier methodology. Under the final rule, the FY 2016 fixed-loss amount will be $16,423, which is both substantially lower than the proposed amount of $18,768 and much closer to the FY 2015 amount of $14,972, which will enable more standard LTCH PPS rate cases to qualify for high-cost outlier payments. Details on the outlier threshold for the site-neutral payment tier are below.

IMPLEMENTATION OF LTCH SITE-NEUTRAL PAYMENT

As noted, this rule adds a site-neutral component to the LTCH PPS beginning with cost-reporting periods starting Oct. 1, 2015 and later. In the LTCH impact file that accompanies the rule, CMS estimates that 46 percent of the LTCH cases in FY 2014 would have fallen into the site-neutral category. This estimate is in line with AHA's prior

estimate of 47 percent. **The AHA is updating our analyses on LTCH site-neutral payment, including LTCH-specific impact estimates that will be shared with each AHA member in the coming weeks.**

Calculation of the LTCH Site-neutral Rate

Site-neutral payment rates will be the lower of the inpatient PPS-comparable per-diem amount, plus any outlier payments, or 100 percent of the estimated cost of the case. The sections below describe how CMS calculates these amounts, including statutorily required outlier payments. Site-neutral payment will be phased in on a rolling basis according to cost reporting periods start dates, beginning with those that start on Oct. 1, 2015. For cost reporting periods beginning in FYs 2016 and 2017, site-neutral cases will be paid a 50-50 blend of the standard LTCH PPS rate and the applicable site-neutral rate. Following the initial two cost reporting periods, full site-neutral rates will take effect.

Proposed Calculation of the Inpatient PPS-comparable Per-diem Amount. In order to calculate the inpatient PPS-comparable per-diem amount, CMS first calculates an amount comparable to what would be paid under the inpatient PPS by adding the operating inpatient PPS standardized amount and the capital inpatient PPS federal rate. Each component is adjusted for the inpatient PPS MS-DRG weight, the LTCH's area wage index, the inpatient PPS labor-related share and cost of living adjustments, where applicable, indirect medical education costs and the costs of serving a disproportionate share of low-income patients. This adjusted sum is then divided by the inpatient PPS geometric ALOS for the associated MS-DRG and multiplied by the covered days on an LTCH claim. The resulting amount is capped at the adjusted sum of the operating standardized amount and capital federal rate defined above.

After calculating the inpatient PPS-comparable per-diem amount, site-neutral cases whose costs exceed the high-cost outlier threshold amount (defined as the inpatient PPS-comparable per diem amount plus the inpatient PPS fixed loss amount of $22,544) are also eligible for high-cost outlier payments, equal to 80 percent of the difference between the estimated cost of the case and the high-cost outlier threshold.

Calculation of 100 Percent of the Estimated Cost of the Case. CMS will calculate 100 percent of the estimated cost of a case by multiplying the LTCH's hospital-specific cost-to-charge ratio (CCR) by the Medicare allowable charges for the case, which is the same method CMS uses when determining LTCH short-stay and high-cost outlier payments. Under this policy, to calculate a payment for an LTCH site-neutral claim, CMS will use the CCR applied at the time a claim is processed, which generally comes from the most recently settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period. For claims reconciliation during cost report settlement, CMS will use the CCR from the settled cost report that coincides with the discharge. This is consistent with the agency's current methodology for reconciling payments for LTCH high-cost and short-stay outlier cases.

Consistent with current protocols, CMS would have the discretion to decide whether to apply an alternative CCR if it believes that the CCR being applied is inaccurate. In addition, LTCHs continue to have the option of requesting of their CMS regional office a higher or lower CCR, which should be supported by substantial evidence that supports the alternative.

CMS also finalized its proposal that when reconciliation for cost report settlement occurs, site-neutral payments will be adjusted to account for the time value of any underpayments or overpayments. Such adjustment will apply from the midpoint of the cost reporting period to the date of reconciliation. The index used to calculate the time value of any such adjusted funds will align with the Medicare Trust Fund's monthly rate of return.

CMS finalized its proposal that site-neutral cases paid 100 percent of cost will not be eligible for outlier payments because, by definition, the cost of the case cannot exceed the payment for the case.

Blended Payments for Site-neutral Cases. For cost reporting periods beginning in FYs 2016 and 2017, site-neutral cases will be paid a 50-50 blend of the standard LTCH PPS rate and the applicable site-neutral rate. These site-neutral blended payments will be phased in on a rolling basis according to the start date of an LTCH's cost reporting period. All applicable adjustments will apply to both of the rates contributing to the blend. Following this transition period, site-neutral cases will be paid fully site-neutral rates.

In addition, the final rule makes a technical correction to the LTCH relative weight and ALOS data for the psychiatric and rehabilitation MS-LTC-DRGs noted above and listed in Table 11 in the rule. Under the two-tiered system, LTCH PPS weights will be calculated using only standard LTCH PPS cases. However, for the calculation of blended rates during the two-year transition to the new policy, these psychiatric and rehabilitation MS-LTC-DRGs will be assigned FY 2015 MS-LTC-DRG weights and average lengths of stay. The proposed rule inadvertently displayed the FY 2016 IPPS MS-DRG data for these MS-LTC-DRGs. Table 11 is available online at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html

When evaluating LTCH claims for FY 2014, the AHA found that approximately half of claims that qualify for a site-neutral rate will receive a blended rate under the FY 2016 policy, with the remainder of otherwise-site-neutral cases still eligible for a standard LTCH PPS rate due to the LTCH's cost reporting period start date.

Budget-neutrality Adjustments (BNA) for Site-neutral High-cost Outlier Cases. CMS finalized a BNA for site-neutral cases paid a high-cost outlier amount, stating that such a reduction is needed to ensure that site-neutral high-cost outlier payments do not increase aggregate LTCH PPS payments. While the final rule tightened the scope of the BNA by narrowing its application to the site-neutral portion of blended rates, the agency more than doubled the rate (from 2.3 percent to 5.1 percent) to account for the more targeted policy. CMS's application of this BNA is one of several outlier-related errors not fixed by the final rule, despite advocacy by the AHA in both our June 15 comment letter and extensive meetings with the agency. Taken as a whole, these errors result in the underpayment of LTCH site-neutral outlier cases.

A central problem is that the agency is applying duplicative BNAs to site-neutral outlier cases paid a blended rate:

- The first BNA of 5.1 percent is applied within the inpatient PPS to inpatient PPS rates that are used as the basis of LTCH site-neutral rates.
- The second BNA of 5.1 percent is applied within the framework of the LTCH PPS to the site-neutral portion of the blend.

These multiple BNAs result in the site-neutral portion of the blend being lower than the corresponding inpatient PPS rate.

Reconciliation of Site-neutral Payments. CMS withdrew its proposal to reconcile site-neutral payments using the CCR and charge data for the cost report associated with the discharge, when that cost report is settled. However, CMS will include site-neutral high-cost outlier payments in the existing outlier reconciliation policy. Also, CMS stated that it may implement the proposed reconciliation policy in the future, after gaining experience under the dual-rate system.

Interrupted Stay and 25% Rule Policies. CMS finalized its proposal to apply both the LTCH interrupted stay and 25% Rule policies to site-neutral cases. While currently subject to a statutory moratorium on full implementation, the 25% Rule imposes a Medicare payment reduction for LTCH admissions from a general acute-care hospital that exceed a specified threshold. 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 agency also noted that it will reconsider waiving these policies for site-neutral cases once it gains more experiences with the new two-tiered system.

LTCH Discharge Ratio Requirement. As required by BiBA, in FY 2016, CMS will 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. The final rule also clarifies that the ratio excludes Medicare Advantage patients from both the numerator and denominator of the ratio.

Short-stay Outlier (SSO) Adjustment. CMS will not apply the SSO payment adjustment to site-neutral cases, as they – like a majority of SSO cases – are already subject to significant payment reductions.

Proposed Changes to LTCH ALOS Calculation

To comply with statutory requirements, CMS will change the calculation of the ALOS for LTCHs. Today, to be classified as an LTCH, a hospital must maintain an ALOS of greater than 25 days. Medicare ALOS is calculated by dividing the total number of covered and non-covered Medicare inpatient days by the total number of Medicare discharges. As required by law, this methodology will be modified by removing from the calculation LTCH cases paid a site-neutral rate or by a Medicare Advantage plan. In the final rule, CMS finalizes an altered position, relative to that in the proposed rule, which will allow only hospitals classified as LTCHs as of December 10, 2013 to remove site-

neutral and Medicare advantage cases from their ALOS calculation, which will result in fewer LTCHs qualifying for this modification to the ALOS calculation.

LTCH QUALITY REPORTING PROGRAM (LTCH QRP)

The Affordable Care Act mandated that reporting of quality measures for LTCHs begin no later than FY 2014. Failure to comply with LTCH Quality Reporting Program (LTCH QRP) requirements will result in a 2 percentage point reduction to the LTCH's annual market-basket update.

For the FY 2018 LTCH QRP, the agency finalizes the use of 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. A detailed summary of the IMPACT Act's requirements can be found in the AHA's Oct. 16, 2014 *Legislative Advisory*. CMS also re-adopts its previously finalized all-cause readmission measure so it reflects the version of the measure recently endorsed by the National Quality Forum (NQF). Table 1 below summarizes the finalized measures for the LTCH QRP.

Table 1: Finalized Measures for the LTCH QRP, FY 2014 – FY 2018

Measure	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
Central line-associated blood stream infection (CLABSI)	X	X	X	X	X
Catheter-associated urinary tract infection (CAUTI)	X	X	X	X	X
Percent of residents or patients with pressure ulcers that are new or worsened	X	X	X	X	X^F
Percent of residents or patients who were assessed and appropriately given the seasonal influenza vaccine			X	X	X
Influenza vaccination coverage among health care personnel			X	X	X
Methicillin-resistant *Staphylococcus aureus* bacteremia				X	X
Clostridium difficile bacteremia				X	X
Unplanned all-cause, all-condition readmissions for 30-day post-discharge from LTCHs				X	X^F
Application of percent of residents experiencing one or more falls with major injury (Long stay)					X^F
Functional Status: Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function					X^F
Functional Status: Change in mobility among LTCH patients requiring ventilator support					X
Ventilator-associated Event Outcome Measure					X

X = Finalized
X^F= Finalized in previous rules, re-adopted in FY 2016 LTCH PPS Final Rule

FY 2018 Measurement Proposals

Timing of IMPACT Act Implementation. The IMPACT Act states that penalties for non-compliance with the new LTCH QRP measure requirements under the act will begin on Oct. 1, 2016 (i.e., FY 2017). However, CMS will use an implementation timeframe whereby IMPACT Act reporting requirements will be tied to payment in the fiscal year that begins two years after they are adopted in rulemaking. **As a result, the LTCH QRP measures CMS adopts to fulfill IMPACT Act requirements will not affect LTCH payment until FY 2018.** The agency suggests such a timeframe "reflects operational and other practical constraints, including the time needed to specify and adopt valid and reliable measures, collect the data, and determine whether an LTCH has complied with our quality reporting requirements." CMS also states the timeframe is consistent with the approach used for the LTCH QRP and other quality reporting programs.

IMPACT Act Measures. 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 will use the three previously adopted measures described below.

Pressure Ulcers. To address the IMPACT Act's "skin integrity" measure domain, CMS will use the LTCH QRP's existing pressure ulcer measure. 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. CMS will continue collecting measure data using the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set, with data submitted using CMS's Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. Additional details on this measure can be found on CMS's LTCH QRP website.

Major Falls. To address the IMPACT Act domain of "major falls," CMS re-adopts the LTCH QRP's measure assessing the percentage of patients that experience one or more falls with major injury. CMS will continue collecting measure data using the LTCH CARE Data Set, with data submitted using the agency's QIES ASAP system. 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 will continue to use this measure because it believes it meets the IMPACT Act's requirement that measures be "interoperable" across care settings. **While the AHA agrees it is reasonable for CMS to select a measure that has already been finalized for the LTCH QRP, we continue to believe the measure should be NQF-endorsed for use in LTCHs before it is adopted for the program.**

Functional Status. To address the IMPACT Act domain of "functional status, cognitive function and changes in function and cognitive function," CMS re-adopts the functional status assessment measure it adopted for the FY 2018 LTCH QRP in the FY 2015 LTCH PPS proposed rule. This 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. In general, functional status

measures assess the extent to which patients regain the ability to perform activities (or "functions") essential to daily living.

CMS will 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 will 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 include a six-level rating scale. Additionally, LTCH clinicians must record a numerical functional goal score at admission for at least one of the assessment items. LTCHs will 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 disagreed with CMS's decision to finalize this measure in last year's rule. We remain concerned this measure will be burdensome to collect, and lacks the reliability and accuracy needed for measures in national programs.

Readmissions Measure. CMS adopted a readmission measure for the FY 2017 LTCH QRP program in the FY 2014 LTCH PPS final rule. For FY 2018, CMS re-adopts the version of the measure endorsed by the NQF in December 2014. This measure assesses the rate of readmissions to general acute-care hospitals and LTCHs within 30 days of discharge from an LTCH. The measure is calculated using Medicare fee for service (FFS) claims data, and captures returns of Medicare patients within 30 days of LTCH discharge. It applies regardless of whether the patient was originally discharged to the community or another care setting of lesser intensity (e.g., skilled nursing facilities, home health, inpatient rehabilitation). 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).

The AHA remains concerned that the readmission measure is not adjusted for sociodemographic factors beyond the LTCH's control, such as income or dual-eligibility for Medicare or Medicaid. A substantial body of research shows these factors greatly influence readmission rates. The AHA continues to urge CMS to incorporate sociodemographic adjustment into all of its readmissions measures to ensure providers' performance does not suffer for factors beyond their control.

Data Submission Requirements

Data Submission Timelines. CMS finalizes several revisions to the data collection and submission timeframes for the LTCH QRP for FY 2017 and beyond that it suggests will "align data submission and correction deadlines" with other quality reporting programs to facilitate public reporting. Most notably, LTCHs will have 4.5 months (approximately 135 days) from the end of a calendar year (CY) to submit required data. LTCHs currently have approximately 45 days from the end of a CY quarter to submit data. The new timeframes will 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. The finalized data submission timeframes are outlined in Appendix A of this advisory.

LTCH QRP Public Reporting

CMS will begin reporting each LTCH's performance on certain LTCH QRP measures publicly no later than the fall of 2016. CMS again indicates it may use its *Hospital Compare* website to display measure information. CMS will report four LTCH QRP measures:

- CAUTI
- CLABSI
- Pressure ulcers
- Readmissions

The initial CAUTI, CLABSI and pressure ulcer measure data will reflect LTCH performance during CY 2015. The readmission measure will measure performance for CYs 2013 and 2014.

Similar to other CMS quality reporting programs, the agency will give LTCHs a 30-day period to preview their performance. However, this 30-day period will not provide an opportunity to submit corrections to the data. Instead, CMS states that its decision to extend the data submission period for LTCH data allows LTCHs sufficient opportunity to review and submit corrections to their data. CMS suggests it is developing a process to allow LTCHs to review and correct submitted data using the QIES ASAP and National Healthcare Safety Network (NHSN) systems.

The agency intends to announce the preview period, as well as the specific date when it would begin to publicly display data, using its listservs, website and other communications vehicles.

FURTHER QUESTIONS

For questions regarding payment provisions, contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org. For questions regarding quality-related provisions, contact Akin Demehin, senior associate director of policy, at ademehin@aha.org.

Appendix A

Finalized Data Collection and Submission Deadlines for LTCH QRP Measures, FY 2017 and Beyond

Key:

F	Finalized in FY 2016 LTCH PPS Proposed Rule
N	Measure is collected and reporting using the CDC's National Healthcare Safety Network (NHSN)
Q	Measure is collected using the LTCH CARE Data Set and submitted using the CMS Quality Improvement Evaluation System (QIES)
C	Measure is calculated using Medicare claims data

Measure	FY 2017 Data Collection	FY 2017 Deadline	FY 2018 Data Collection	FY 2018 Deadline	Subsequent Fiscal Year Data Collection	Subsequent Fiscal Year Deadlines
Central-Line Associated Blood Stream Infection (CLABSI)[N]	Jan. 1 – Mar. 31, 2015 Apr. 1 – Jun. 30, 2015 Jul. 1 – Sep. 30, 2015 Oct. 1 – Dec. 31, 2015	May 15, 2015 Aug. 15, 2015 Nov. 15, 2015 May. 15, 2016[F]	Jan. 1 – Mar. 31, 2016 Apr. 1 – Jun. 30, 2016 Jul. 1 – Sep. 30, 2016 Oct. 1 – Dec. 31, 2016	Aug. 15, 2016[F] Nov. 15, 2016[F] Feb. 15, 2017[F] May. 15, 2017[F]	Q1: Jan. 1 – Mar. 31[F] Q2: Apr. 1 – Jun. 30[F] Q3: Jul. 1 – Sep. 30[F] Q4: Oct. 1 – Dec. 31[F]	Quarterly, approximately 135 days after the end of each calendar quarter[F]
Catheter-Associated Urinary Tract Infection (CAUTI)[N]	Jan. 1 – Mar. 31, 2015 Apr. 1 – Jun. 30, 2015 Jul. 1 – Sep. 30, 2015 Oct. 1 – Dec. 31, 2015	May 15, 2015 Aug. 15, 2015 Nov. 15, 2015 May. 15, 2016[F]	Jan. 1 – Mar. 31, 2016 Apr. 1 – Jun. 30, 2016 Jul. 1 – Sep. 30, 2016 Oct. 1 – Dec. 31, 2016	Aug. 15, 2016[F] Nov. 15, 2016[F] Feb. 15, 2017[F] May. 15, 2017[F]	Q1: Jan. 1 – Mar. 31[F] Q2: Apr. 1 – Jun. 30[F] Q3: Jul. 1 – Sep. 30[F] Q4: Oct. 1 – Dec. 31[F]	Quarterly, approximately 135 days after the end of each calendar quarter[F]
Percent of residents or patients with pressure ulcers that are new or worsened[Q]	Jan. 1 – Mar. 31, 2015 Apr. 1 – Jun. 30, 2015 Jul. 1 – Sep. 30, 2015 Oct. 1 – Dec. 31, 2015	May 15, 2015 Aug. 15, 2015 Nov. 15, 2015 May. 15, 2016[F]	Jan. 1 – Mar. 31, 2016 Apr. 1 – Jun. 30, 2016 Jul. 1 – Sep. 30, 2016 Oct. 1 – Dec. 31, 2016	Aug. 15, 2016[F] Nov. 15, 2016[F] Feb. 15, 2017[F] May. 15, 2017[F]	Q1: Jan. 1 – Mar. 31[F] Q2: Apr. 1 – Jun. 30[F] Q3: Jul. 1 – Sep. 30[F] Q4: Oct. 1 – Dec. 31[F]	Quarterly, approximately 135 days after the end of each calendar quarter[F]

Measure	FY 2017 Data Collection	FY 2017 Deadline	FY 2018 Data Collection	FY 2018 Deadline	Subsequent Fiscal Year Data Collection	Subsequent Fiscal Year Deadlines
Percent of residents or patients who were assessed and appropriately given the seasonal influenza vaccine[Q]	Oct. 1 – Dec. 31, 2015 Jan. 1 – Mar. 31, 2016	Feb. 15, 2016 May 15, 2016	Oct. 1 – Dec. 31, 2016** Jan. 1 – Mar. 31, 2017**	May. 15, 2017[F**] Aug 15, 2017[F**]	Oct. 1 – Dec. 31[F] Jan. 1 – Mar. 31 [F]	May 15 [F] Aug. 15 [F]
Influenza vaccination coverage among healthcare personnel[N]	Oct. 1, 2015 – Mar. 31, 2016	May 15, 2016[F]	Oct. 1, 2016– Mar. 31, 2017[F]	Aug. 15, 2017[F]	Oct. 1 – Mar. 31 [F]	Aug. 15 [F]
Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia[N]	Jan. 1 – Mar. 31, 2015 Apr. 1 – Jun. 30, 2015 Jul. 1 – Sep. 30, 2015 Oct. 1 – Dec. 31, 2015	May 15, 2015 Aug. 15, 2015 Nov. 15, 2015 May. 15, 2016[F]	Jan. 1 – Mar. 31, 2016 Apr. 1 – Jun. 30, 2016 Jul. 1 – Sep. 30, 2016 Oct. 1 – Dec. 31, 2016	Aug. 15, 2016[F] Nov. 15, 2016 [F] Feb. 15, 2017 [F] May. 15, 2017 [F]	Q1: Jan. 1 – Mar. 31[F] Q2: Apr. 1 – Jun. 30[F] Q3: Jul. 1 – Sep. 30[F] Q4: Oct. 1 – Dec. 31[F]	Quarterly, approximately 135 days after the end of each calendar quarter[F]
Clostridium difficile (C Difficile)[N]	Jan. 1 – Mar. 31, 2015 Apr. 1 – Jun. 30, 2015 Jul. 1 – Sep. 30, 2015 Oct. 1 – Dec. 31, 2015	May 15, 2015 Aug. 15, 2015 Nov. 15, 2015 May. 15, 2016[F]	Jan. 1 – Mar. 31, 2016 Apr. 1 – Jun. 30, 2016 Jul. 1 – Sep. 30, 2016 Oct. 1 – Dec. 31, 2016	Aug. 15, 2016[F] Nov. 15, 2016 [F] Feb. 15, 2017 [F] May. 15, 2017 [F]	Q1: Jan. 1 – Mar. 31[F] Q2: Apr. 1 – Jun. 30[F] Q3: Jul. 1 – Sep. 30[F] Q4: Oct. 1 – Dec. 31[F]	Quarterly, approximately 135 days after the end of each calendar quarter[F]
Unplanned all-cause, all condition readmissions to LTCHs.[C]	Two years of Medicare claims: Jan. 1, 2013 – Dec. 31, 2014	N/A – calculated by CMS	Not addressed in final rule	Not addressed in final rule	Not addressed in final rule	Not addressed in final rule

Measure	FY 2017 Data Collection	FY 2017 Deadline	FY 2018 Data Collection	FY 2018 Deadline	Subsequent Fiscal Year Data Collection	Subsequent Fiscal Year Deadlines
Percent of residents experiencing one or more falls with major injury (Long stay)[Q]	N/A	N/A	Apr. 1,– Jun. 30, 2016 Jul. 1 – Sep. 30, 2016 Oct. 1 – Dec. 31, 2016	Nov. 15, 2016[F] Feb. 15, 2017[F] May. 15, 2017[F]	Q1: Jan. 1 – Mar. 31[F] Q2: Apr. 1 – Jun. 30[F] Q3: Jul. 1 – Sep. 30[F] Q4: Oct. 1 – Dec. 31[F]	Quarterly, approximately 135 days after the end of each calendar quarter[F]
Functional Status: Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function[Q]	N/A	N/A	Apr. 1 – Jun. 30, 2016 Jul. 1 – Sep. 30, 2016 Oct. 1 – Dec. 31, 2016	Nov. 15, 2016[F] Feb. 15, 2017[F] May. 15, 2017[F]	Q1: Jan. 1 – Mar. 31[F] Q2: Apr. 1 – Jun. 30[F] Q3: Jul. 1 – Sep. 30[F] Q4: Oct. 1 – Dec. 31[F]	Quarterly, approximately 135 days after the end of each calendar quarter[F]
Functional Status: Change in mobility among LTCH patients requiring ventilator support[Q]	N/A	N/A	Apr. 1 – Jun. 30, 2016 Jul. 1 – Sep. 30, 2016 Oct. 1 – Dec. 31, 2016	Nov. 15, 2016[F] Feb. 15, 2017[F] May. 15, 2017[F]	Q1: Jan. 1 – Mar. 31[F] Q2: Apr. 1 – Jun. 30[F] Q3: Jul. 1 – Sep. 30[F] Q4: Oct. 1 – Dec. 31[F]	Quarterly, approximately 135 days after the end of each calendar quarter[F]
Ventilator-Associated Event Outcome Measure[N]	N/A	N/A	Jan. 1 – Mar. 31, 2016 Apr. 1 – Jun. 30, 2016 Jul. 1 – Sep. 30, 2016 Oct. 1 – Dec. 31, 2016	Aug. 15, 2016[F] Nov. 15, 2016[F] Feb. 15, 2017[F] May. 15, 2017[F]	Q1: Jan. 1 – Mar. 31[F] Q2: Apr. 1 – Jun. 30[F] Q3: Jul. 1 – Sep. 30[F] Q4: Oct. 1 – Dec. 31[F]	Quarterly, approximately 135 days after the end of each calendar quarter[F]

**The dates here reflect the AHA's understanding of the data collection and submission timeframes. The FY 2018 timeframes listed in the FY 2016 LTCH PPS final rule appear to be the same ones the agency previously finalized for FY 2017.