

June 25, 2018

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

RE: CMS-1694-P. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims.

Dear Ms. Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including 312 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) 2019 proposed rule for the inpatient and LTCH prospective payment systems (PPS). This letter addresses the LTCH payment and quality-reporting provisions in the proposed rule. We are submitting separate letters on the agency's inpatient PPS (IPPS) proposals and request for information related to price transparency.

The AHA supports several of the proposed rule's provisions. **In particular, we appreciate and endorse the agency's proposal to permanently withdraw the 25% Rule; however, we oppose the associated budget neutrality adjustment (BNA) proposed by CMS.** We also support the proposed changes related to co-located satellite facilities, and the streamlining of the LTCH quality reporting program (QRP). In addition, this letter reiterates our concerns related to underpayment for site-neutral cases.



PAYMENT-RELATED PROPOSALS

PERMANENT WITHDRAWAL OF THE 25% RULE

The AHA is very supportive and appreciative of CMS's proposal to permanently withdraw the 25% Rule, and we encourage CMS to finalize this policy effective Oct. 1, 2018. However, we oppose this provision's application of a one-time, permanent BNA of -0.9 percent that CMS proposes to apply to the LTCH PPS standard federal payment rate for the proposed elimination of the 25% Rule.

The 25% Rule reduces LTCH payments to an "IPPS-equivalent" level for patients transferring from a general acute-care hospital to an LTCH and who exceed a particular referral threshold. The referral threshold varies by LTCH type. For example, rural LTCHs have a more lenient threshold of 50 percent. For many years, the policy was partially in effect due to multiple congressional interventions that each temporarily blocked full implementation. For the current fiscal year, the 25% Rule is partially in effect due to the regulatory pause CMS authorized in the FY 2018 final rule. Under these interim 25% Rule thresholds, members report that, to the extent possible, they are already identifying non-compliant cases and returning to CMS the difference between actual payment and the IPPS-equivalent amount. A full 25% Rule refund to CMS is often not possible for sites that cannot access from their referral hospitals a validation of which cases were high-cost outliers, which are exempt from the policy.

Reduced Administrative Burden. While withdrawal of the 25% Rule would be beneficial for patient access to care, it also would improve LTCH operations by ending the substantial allocation of staff resources to oversee compliance with the policy. Typically, LTCHs have dedicated multiple personnel to monitor compliance with the policy, align compliance levels for each referring hospital with its admissions practices per hospital – often a daily exercise – and calculate impact and the associated refunds to CMS. We appreciate CMS's recognition of the LTCH field's need for this relief, especially in light of new operational pressures under LTCH site-neutral payment. In addition, the removal of the policy also would reduce burden for CMS and its contractors.

LTCH Volume Is Being Impacted by Alternative Payment Models (APMs) and Medicare Advantage (MA). Both APMs, such as accountable care organizations and bundled payment, and MA plans are, in general, reducing LTCH utilization due to the setting's high cost. With very few exceptions, our LTCH members across the nation report significant challenges in persuading case managers from these entities to approve LTCH admissions in their work to guide post-hospital placements. **The business model impact of APMs and MA that restrict LTCH access further renders the 25% Rule unnecessary and excessive.**

The 25% Rule Continues to be an Arbitrary Policy. Since its proposal and implementation, the 25% Rule lacked a policy rationale for its role in limiting admissions of cases that otherwise met LTCH admissions criteria. The Medicare Payment Advisory Commission (MedPAC) agreed with our critique of the policy's non-clinical and arbitrary nature, calling it "blunt" and "flawed" in a March 2011 report to Congress. Since its implementation, medically appropriate beneficiaries have faced reduced access to LTCHs for cases that would have been non-compliant with the 25% Rule. Likewise, retrospective 25% Rule refunds to CMS returned payments that

were otherwise appropriate reimbursement for treating clinically appropriate LTCH patients. **This fundamentally flawed policy should neither have been used to limit LTCH access nor as the basis for refunds to CMS for otherwise appropriate care. Accordingly, it should not be used to further reduce payments through the proposed budget neutrality adjustment.**

Site-neutral Cuts Obviate the Need for a 25% Rule BNA. As discussed in [our March 23 letter](#) to CMS and reiterated below, the implementation of LTCH site-neutral payment, which began in 2015, is bringing a major transformation to the LTCH field. Specifically, the scale of the site-neutral cuts is materially reducing the overall volume of LTCH cases, and, commensurately, aggregate Medicare payments to LTCHs. Further, as demonstrated below, Medicare is underpaying the cost of treating site-neutral cases both under a blended payment arrangement during the transition to full site-neutral payment, and under full site-neutral payment. Indeed, while we have still not seen the full magnitude of the LTCH site-neutral payment policy, its early years of implementation clearly point to a continued downsizing of the LTCH field through closures and overall volume reduction.

The AHA evaluated claims from FYs 2016 and 2017, as well as projected case volumes for 2018 and 2019 to estimate the fiscal impact of LTCH site-neutral payment on the LTCH field. As shown in Chart 1 below, in its first four years, the policy reduced or is expected to reduce aggregate Medicare payments to LTCHs (when compared with what they would have received under a full standard rate payment) by over \$1.1 billion.¹

Chart 1: Estimated Impact of LTCH Site-neutral Payments from FYs 2016 through 2019				
Fiscal Year	Total Payments if Paid at Full Standard Rate	Total Blended Payments (50% Site-neutral/50% Standard Rate)	Difference ²	Percent Difference
2016	\$1.880 B	\$1.749 B	-\$131 M	-7%
2017	\$1.417 B	\$1.034 B	-\$382 M	-27%
2018	\$1.147 B	\$0.808 B	-\$339 M	-30%
2019	\$0.910 B	\$0.645 B	-\$266 M	-29%
Total	\$5.354 B	\$4.236 B	-\$1.118 B	-21%

Sources: FY 2016 & FY 2017 MedPAR files; FY 2016-2018 final rule and FY 2019 proposed rule CMS public use files for inpatient PPS and LTCH PPS; CMS Provider Specific File (April 2018 update).

¹ In conducting this analysis, we assumed that site-neutral volume in FY 2018 & 2019 drops by the same percent per year as it did between FY 2016 & 2017 (approximately 20% per year). Should site-neutral volume drop by a smaller percentage, the estimated total impact shown in the table would be higher; should site-neutral volume drop by a larger percentage, the estimated impact would be lower.

² In FY 2016, LTCHs were paid for all discharges (including their site-neutral cases) at the LTCH PPS standard rate until the start of their first cost reporting period beginning after October 1, 2015; this accounts for the smaller difference in FY 2016 between the blended payment and the payment at the full standard rate.

Given the transformative impact of this \$1.1 billion site-neutral payment cut on the LTCH field, finalization of the proposed 25% Rule BNA would be wholly unwarranted and excessive.

The Proposed BNA Departs from Prior CMS Policies. **We note that prior interventions by Congress and CMS to pause full implementation of the 25% Rule, including the 12-month pause in the FY 2018 final rule, were never paired with a BNA.** Specifically, although these interventions were the same as CMS's proposed repeal, neither Congress nor CMS took the step of combining these changes with even a one-year adjustment, much less a multiple-year or permanent cut. Yet, despite the considerable history of congressional and CMS actions on this policy, this rule lacks an explanation regarding why this 25% Rule change is different and, unlike these prior changes, warrants an adjustment. **Therefore, to align this rule with prior CMS policy, the proposed BNA should be withdrawn.**

Concerns with the Proposed Budget Neutrality Methodology. **While we strongly oppose the -0.9 percent BNA that CMS is proposing to ensure that 25% Rule elimination would occur in a budget-neutral fashion, if the agency proceeds with this adjustment, it must recalculate and right-size this factor to account for shortcomings in its methodology.** (We note that the budget neutrality factor of 0.990535 calculated by CMS translates into the -0.9 percent BNA.)

In particular, the following two shortcomings must be addressed:

- When projecting LTCH volume in FY 2019, CMS used the FY 2016 claims as its baseline. However, in that year, the 25% Rule did not apply to freestanding LTCHs so they were not restricting their admissions practices to achieve compliance with the rule. This limitation of the FY 2016 claims must be accounted for in the agency's use of these data to project what FY 2019 case volume would be in FY 2019, under full implementation of the policy to every LTCH. Failure to do so misstates the size of the proposed BNA because it does not take into account the fact that in FY 2016 the threshold percentages were eliminated for several freestanding LTCHs, thus causing CMS to estimate many more cases exceeding the lower 25 percent threshold than should be the case. In other words, the proposed cut is overstated in the rule, and should be zero, or at least reduced.
- When projecting what LTCH case volumes would be in FY 2019, CMS must estimate what the impact of the full 25% Rule would be in that year. However, the FY 2016 data used by CMS to calculate this projection, only reflect the impact of a partially-implemented 25% Rule using more lenient (higher) thresholds. We can look at real-world experience under the partially implemented policy to know that providers denied otherwise clinically-appropriate cases in order to comply with the rule. We would reasonably expect the volume of such denials to be substantially larger in FY 2019 under the full policy. CMS must account for this larger volume of FY 2019 admissions denials, which should reduce the size of the proposed cut.

In calculating the size of the proposed BNA, CMS must account for these limitations of the FY 2016 data.

Further, CMS's proposed methodology for calculating the BNA departs from that used to calculate the FY 2018 BNA related to LTCH short-stay outlier (SSO) policy revisions. In the case of the SSO BNA, the agency undertook a series of steps which included a behavioral assumption by its actuaries that the proposed SSO methodology would result in a 10 percent reduction in non-SSO cases and a corresponding increase of 10 percent in SSO cases. **In alignment with this precedent, if CMS proceeds with the proposed BNA, CMS should apply a behavioral adjustment to decrease the size of the proposed cut.**

In addition, we note that the proposed cut would have a permanent impact on the field, which CMS estimates would be approximately \$36 million for FY 2019 *and every subsequent year*. It is indefensible that this across-the-board cut would have a permanent effect on every LTCH, especially the LTCHs that reduced volume to comply with the policy. As such, if CMS persists in applying a BNA to the LTCH standard rate in FY 2019, which we oppose, the agency should not only address the concerns described above, but after applying this BNA in FY 2019, the proposed cut should be added back to the LTCH standard rate in FY 2020. **In other words, this 25% Rule BNA, if implemented at all, should not be a permanent cut and should have no impact after FY 2019.**

Also, in calculating the proposed BNA, CMS states that because site-neutral payments in FY 2019 will still be based on a 50/50 blend of site-neutral and standard rate payments, that its calculation of the proposed BNA must account for the change in payments to both site-neutral as well as standard rate cases. However, even though CMS is proposing a permanent cut that will also affect FY 2020 and beyond, CMS's methodology has not taken into account that starting in FY 2020, site-neutral cases will not be paid based on the blend. Failure to account for the phase-out of blended payments for cost reports beginning on or after Oct. 1, 2019, would overstate the size of the proposed cut, should it be applied after that point. **Therefore, while we believe that the BNA should be fully withdrawn, should CMS proceed with permanently implementing this cut, the amount should be reduced to reflect this phase-out of blended payments in FY 2020 and beyond.**

CONCERNS WITH NEW PAYMENT CUT FOR SITE-NEUTRAL CASES

In March 2018, CMS retrospectively implemented a 4.6 percent payment reduction for site-neutral cases authorized by the Bipartisan Budget Act of 2018 for FYs 2018 through 2026. Per "internal transmittal" 3986 from March 2018 and public transmittal 4046 issued in May 2018, the effective date of this cut is Oct. 1, 2017. While we understand the statutory reference implementing this cut is particular fiscal years, the cut is an offset for site-neutral relief authorized by the same legislation, which is being implemented on a cost reporting period schedule. **As such, we urge CMS to align the rollout of both of these policies on a cost reporting period schedule.** These two policies were designed as a pair and should be implemented as such. Moving forward, we urge CMS to raise its level of transparency for any cut that takes effect prior to notification to the field. In this case, CMS contractors received authorization from CMS via "internal transmittal" 3986 and began its implementation prior to any notification of stakeholders. Providers only learned of this implementation after CMS contractors began to recoup funds.

SITE-NEUTRAL CASES ARE BEING UNDERPAID

As the AHA has reported to CMS, LTCH site-neutral cases are being materially underpaid. Yet, the proposed rule only makes brief mention of CMS's continuing expectation that these cases will eventually have a cost and length-of-stay profile that mirrors those of inpatient PPS cases with the same DRG. Contrary to this view, we have seen no movement in that direction since the implementation of site-neutral payment began, as shown in Chart 2 below. We also note that the rule's mention of its projected FY 2019 fiscal impact on site-neutral cases makes no reference to the disturbing underpayment pattern discussed below in a re-iteration of the concerns we shared in our March 2018 letter to CMS that is cited on page 3 of this letter.

Background on LTCH Site-neutral Payment Policy and the Duplicative Budget Neutrality Adjustments. The Bipartisan Budget Act of 2013 established a LTCH site-neutral payment rate for certain cases. Since the policy's implementation began in fall 2015, it has affected approximately one out of two LTCH cases. Once fully phased-in, the site-neutral payment rate will be only about 42 percent of the standard LTCH PPS rate, based on FY 2019 estimates by the AHA. However, when paying site-neutral cases, CMS applies two BNAs related to high-cost outlier (HCO) payments: the first occurs during the establishment of the inpatient PPS rates used as the basis for LTCH site-neutral payment, the second occurs while setting the LTCH payment. The AHA and MedPAC both agree that the second adjustment is duplicative and should not occur. This is because the inpatient PPS-standard payment amount – the basis for the LTCH site-neutral “IPPS-comparable payments” – already is adjusted to account for HCO budget neutrality. Specifically, in its May 31, 2016 comment letter on the FY 2017 inpatient PPS/LTCH PPS proposed rule, MedPAC states that:

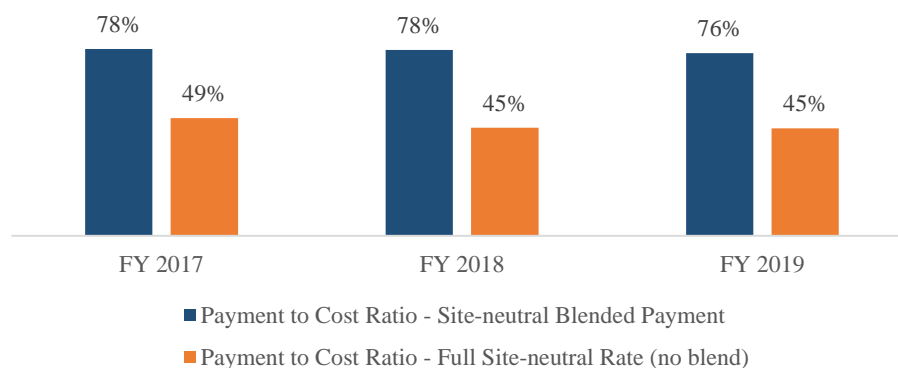
“[g]iven that the IPPS standard payment amount is already adjusted to account for HCO payments, CMS’ proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative and exaggerates the disparity in payment rates across provider settings. Given this duplication, CMS should not adjust the site-neutral rate further.”

The AHA's concerns regarding the duplicative BNA were explained in detail in our comment letters on the FYs 2017 and 2018 proposed rules for the LTCH PPS, as well as during in-person meetings and calls with CMS staff.

In partial recognition of these concerns, CMS, in FY 2017, stopped applying the second BNA to the HCO portion of LTCH site-neutral payments. However, it still applies to the non-HCO portion of the site-neutral portion of the blend. Based on our analysis of FY 2016 MedPAR data, the AHA estimates that the second BNA inappropriately reduces aggregate payments (of the fully implemented policy) by approximately \$28 million per year, a substantial amount.

Underpayment of LTCH Site-neutral Cases. While the AHA previously has weighed in regarding the redundant BNA, our concerns have grown due to our analysis demonstrating the vast underpayment that is occurring for LTCH site-neutral cases. This underpayment threatens access to care and is unnecessarily exacerbated by the unwarranted 5.1 percent BNA. Specifically, as shown in Chart 2 below, under the full site-neutral policy, average payment covers only 45 percent of the cost of care, even though these cases have a high level of medical complexity, on average. Unfortunately, even under the 50/50 blended payments during the transition to full site-neutral payment, only an average of 76 percent of costs are covered.

Chart 2. Payment to Cost Ratios for
LTCH Site-neutral Cases;
With and Without Blended Payment



Sources: FY 2017 MedPAR file; FY 2017 and 2018 final rule and FY 2019 proposed rule CMS public use files for inpatient PPS and LTCH PPS; CMS Provider Specific File (April 2018 update).

Our analyses show that these substantial underpayments are occurring because, contrary to CMS's projections, the acuity level and cost of care for LTCH site-neutral cases far exceed those of comparable inpatient PPS cases.³ One key driver of the higher cost of treating site-neutral cases is that they have a higher average level of clinical acuity. Specifically, we found that 54 percent of these cases have between one and four complications and comorbidities/major complications and comorbidities (CC/MCC), while 42 percent have five or more CC/MCCs (see Chart 3 below). Compared to inpatient PPS cases (those with fewer than three days in the intensive care unit (ICU)), 62 percent have one to four CCs/MCCs but only 12 percent have five or more. Consistent with their higher acuity levels, LTCH site-neutral cases also have an average length of stay of 25.1 days, which is much more similar to that of LTCH cases paid a standard rate than to the 4.0 day average length of stay for comparable inpatient PPS cases. The contrast is equally stark when comparing Medicare payment-to-cost ratios: 0.47 for LTCH site-neutral cases, and 0.99 for inpatient PPS cases with fewer than three ICU days.⁴ Average costs per case for these cases were \$32,941 and \$11,190, respectively.⁵ **Collectively, these data, which also are presented in the chart below, show that LTCH site-neutral cases are, on average,**

³ 2016 MedPAR data.

⁴ Note that overall, Medicare payments to general acute-care hospitals covered only 87 cents for every dollar spent caring for Medicare patients in 2016.

⁵ FY 2016 cases with FY 2018 payment parameters.

sicker and cost three times more than inpatient PPS cases with fewer than three ICU days. Yet, the full site-neutral rate covers less than half the cost of care.

Chart 3. Comparing LTCH Site-neutral Cases & Inpatient PPS Cases with Fewer than 3 ICU Days*		
	IPPS Cases with <3 ICU Days	LTCH Site-neutral Cases
Number of Cases	6,974,091	50,781
Length of Stay	4.0	25.1
% of Cases with 1-4 CC/MCCs	62%	54%
% of Cases with 5+ CC/MCCs	12%	42%
Average Cost	\$11,190	\$32,941
Average Medicare FFS Payment**	\$11,108	\$15,592
Payment to Cost Ratio	0.99	0.47

*FY 2016 cases with FY 2018 payment parameters.

**Without the site-neutral blend.

In summary, AHA continues to have the following concerns:

- The clinical and cost profile of LTCH site-neutral cases continues to be misaligned with its inpatient PPS-based payments, as recognized by CMS in its FY 2018 rulemaking and this rule, and is driving systematic underpayment of these cases.
- The second BNA lacks a policy justification and, as noted by MedPAC, compounds the underpayment of LTCH site-neutral cases.

Given these concerns, we again call on CMS to remove the second site-neutral payment BNA. In addition, in alignment with its plan put forth in the FY 2018 LTCH PPS final rule that stated CMS would continue to monitor the differential between LTCH site-neutral and inpatient PPS cases, we encourage the agency to share with stakeholders in the pending final rule its promised analyses comparing these two groups. In particular, a DRG-level study comparing the relative levels of clinical severity, lengths of stay, cost, and Medicare payment would be of great value to beneficiaries, policymakers, and stakeholders.

PROPOSED CHANGES FOR CO-LOCATED SATELLITES

The AHA thanks CMS for its proposed changes to the separateness and control criteria that apply to satellite hospitals that are excluded from the inpatient PPS and co-located with another excluded hospital. Specifically, we support CMS's proposal to exempt satellites from Medicare separateness and control requirements, in line with changes made in FY 2018 for hospitals-within-a-hospital (HwH). HwHs and satellites would still be held to these requirements when co-located with an inpatient PPS hospital. We support CMS's rationale for this proposed change, agreeing that the definitions for HwHs and satellites are significantly similar and their co-location policies have been based on many of the same concerns, most notably that patients

would be inappropriately transferred from the host hospital to the co-located provider to maximize Medicare payment, rather than to optimize patient care. We appreciate CMS noting that such concerns have been “sufficiently moderated” and no compelling reason exists to treat satellites differently than HwHs with regard to the rules on separateness and control. We also note CMS’s clarification that those co-located satellites that were excluded from the inpatient PPS before Oct. 1, 1995 remain exempt from the separateness and control requirements.

QUALITY REPORTING-RELATED PROPOSALS

LTCH QUALITY REPORTING PROGRAM (LTCH QRP)

The Affordable Care Act mandated the reporting of quality measures and failure to comply with LTCH QRP requirements will result in a 2.0 percentage point reduction to the LTCH’s annual market-basket update. Currently, CMS requires the reporting of 14 quality measures by LTCHs, and plans to require the reporting of five more by FY 2020. CMS proposes to remove two measures for the FY 2020 LTCH QRP and one measure for the FY 2021 LTCH QRP. **The AHA appreciates CMS’s commitment to its Meaningful Measures initiative, which can be seen in the thoughtful analysis and removal of three measures from the LTCH QRP. We encourage CMS to continue to apply the measure removal criteria to other measures in the LTCH QRP, including those more recently adopted in the program, in order to reduce regulatory burden on providers so that they may focus instead on improving patient outcomes.**

FY2020-2021 MEASUREMENT PROPOSALS

Proposed New Measure Removal Factor for Previously Adopted LTCH QRP Measures. In previous rulemaking CMS finalized seven factors to determine whether a measure should be removed from a QRP on a case-by-case basis. The agency proposes to expand the measure removal criteria by adding an eighth factor: “the costs associated with a measure outweigh the benefit of its continued use in the program.” CMS defines “costs” as those affecting providers and clinicians as well as the costs to the agency associated with program oversight. The agency also reiterates that the measure removal evaluation process would continue to be done on a case-by-case basis, and measures that are considered burdensome or “costly” might be retained in the QRP if the benefit to beneficiaries justifies the reporting burden. **The AHA supports the long overdue addition of this measure removal factor.**

Proposed Removal of the National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure. CMS proposes to remove this healthcare-associated infection outcome measure from the FY 2020 LTCH QRP because a measure that is more strongly associated with desired patient outcomes for MRSA bacteremia is available, namely the NHSN Central Line-associated Blood Stream Infection (CLABSI) Outcome Measure. The latter measure captures a wide range of

bloodstream infections, including MRSA bacteremia; thus, the specific MRSA bacteremia measure is duplicative. In addition to this duplicative reporting burden, it is also costly for CMS to maintain both measures and potentially confusing for the public to have overlapping measure rates reported. **The AHA appreciates that CMS identified this duplication, and we support the measure's removal from the LTCH QRP.**

Proposed Removal of the NHSN Ventilator-associated Event (VAE) Outcome Measure. CMS proposes to remove this healthcare-acquired condition outcome measure from the FY 2020 LTCH QRP because LTCHs are currently required to collect and report three other assessment-based quality measures on the topic of ventilator support. Two of these measures were finalized in the FY 2018 LTCH PPS final rule: Compliance with Spontaneous Breathing Trial (SBT) by Day 2 of the LTCH Stay and Ventilator Liberation Rate. The other measure, Change in Mobility among LTCH Patients Requiring Ventilator Support, was finalized in the FY 2015 LTCH PPS final rule.

CMS states that these three measures are more strongly associated with desired patient outcomes – that is, improvement in functional mobility and successful liberation from mechanical ventilation – than the VAE measure. In addition, improvement on these measures is associated with improved outcomes, including a reduction in VAEs. We understand CMS's rationale behind this strategy, which the agency argues rewards providers for performing evidence-based clinical processes rather than punishing providers for caring for gravely ill patients.

However, while we appreciate the elimination of the measure and agree that it overlaps unnecessarily with the other ventilator-related measures recently adopted in the LTCH QRP, **we would recommend ameliorating this duplication by eliminating the less meaningful process measure instead.** In [our comments](#) on the FY 2018 LTCH PPS proposed rule, we raised several concerns about the SBT measure, including the arbitrary and burdensome two-day timeframe. CMS did not address those concerns in the final rule, and thus we continue to be concerned about the appropriateness of that measure. In addition, because two of the three ventilator measures currently in the LTCH QRP have only begun data collection, we do not yet know that these measures will be sufficient to address VAEs. **Thus, we encourage CMS to monitor rates of worsening oxygenation, infection, inflammation, and ventilator-associated pneumonia to ensure that the measure's removal does not unintentionally lead to a rising trend in these events.**

Proposed Removal of the Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) Measure. CMS proposes to remove this process measure from the FY 2021 LTCH QRP as the agency has determined that the costs associated with the measure outweigh the benefit of its continued use in the program. In addition to near-perfect performance by providers on this measure in the 2016-2017 influenza season, CMS notes that data collection associated with the measure is more burdensome than beneficial. Patients are rarely admitted directly from an LTCH; instead, patients are generally discharged from a general acute-care inpatient hospital to an LTCH. It is during that proximal

stay at the inpatient hospital that patients are nearly always given the flu shot; thus, most assessments at LTCHs do not lead to vaccinations and end up as mere paperwork. **While the AHA agrees that influenza is a major issue for the vulnerable patients served by LTCHs, we agree that the removal of the measure would not result in lower quality care and support its removal from the LTCH QRP.**

Proposed Expanded Notification Methods for Noncompliance and Reconsiderations. CMS proposes to expand the methods by which the agency would provide notifications for decisions on noncompliance with LTCH QRP requirements as well as reconsideration requests to include the Quality Improvement and Evaluation System Assessment Submission and Processing (QIES ASAP) system, the U.S. Postal Service, and email from the Medicare Administrative Contractors. **The AHA appreciates CMS responding to provider requests for more methods of communication and supports this change.** We also request additional details on the logistics of these methods of communication, including how providers will need to provide contact information to receive these notifications, who in provider organizations will be able to access the notifications, and a timeline for the change's implementation.

We thank you for the opportunity to comment on this proposed rule. If you have any questions concerning our comments, please feel free to contact me, or have a member of your team contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org regarding the payment provisions, or Caitlin Gillooley, associate director of policy, at cgillooley@aha.org, pertaining to the quality-reporting provisions.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President
Government Relations and Public Policy