American Hospital Association™
Advancing Health in America

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June 9, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services,
Attention: CMS-1785-P
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted Electronically

Re: Medicare Program; Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Provider and Supplier Disclosure of Ownership; 88 Fed. Reg. 26,658 (May 1, 2023).

Dear Administrator Brooks-LaSure:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 250 long-term care hospitals (LTCH), and our clinician partners — more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the fiscal year (FY) 2024 LTCH prospective payment system (PPS) proposed rule. We are submitting separate comments on the rule's inpatient PPS (IPPS) proposals.

AHA and its member LTCHs are extremely concerned about the payment reductions proposed in this rule. If finalized, they would harm not only LTCHs, but also Medicare's most severely ill patient populations and the entire health care continuum. **We are therefore very grateful that CMS has included in this rule a request for comments on how it can mitigate some of these proposed reductions, such as the high-cost outlier (HCO) threshold.**

For important context, LTCHs play a highly specialized role in the care continuum by focusing on caring for critically ill, medically complex patients that require extended

hospital stays. Less than 1% of Medicare discharges from acute-care hospitals are discharged to an LTCH, and they are among the most highly acute patients that exist. With an average length of stay of more than 25 days, these hospitals use their experience to ensure the best possible outcomes for these beneficiaries.

The unique capabilities and care provided by LTCHs was on full display during the COVID-19 public health emergency (PHE). This included LTCHs caring for the most seriously afflicted patients, with COVID-19 patients being three times more likely than non-COVID-19 patients to be admitted to an LTCH. While doing so, LTCHs also assisted their community partners by decompressing acute-care hospitals when there was a shortage of ICU beds.[1] Without the additional capacity these hospitals provided, numerous communities across the country would have faced increased difficulty meeting the demand for care.

As such, and as further explained below, we implore CMS to make significant revisions to some of its proposed policies for FY 2024. Most imperative to address is the proposed fixed-loss threshold for HCO payments, which CMS proposes to increase by 150% compared to FY 2023. **Therefore, we urge CMS to adopt methodological changes that would result in a lower, and more appropriate, threshold.** In addition, we are deeply concerned about the inadequacy of the proposed market basket update given the changing health care system dynamics and its workforce challenges. **As such, we urge CMS to utilize its authority to provide a market basket adjustment to account for what the agency missed in the FY 2022 market basket forecast.**

Proposed FY 2024 LTCH PPS Standard Updates

CMS proposes a market basket update of 3.1%, reduced by a productivity adjustment of 0.2 percentage points, resulting in a net market basket update of 2.9% for FY 2024. We are very concerned that this update, as well as the net FY 2022 payment update of 1.9%, are woefully inadequate and do not capture the unprecedented inflationary environment LTCHs are experiencing. This is because the market basket is a time lagged estimate that uses historical data to forecast into the future. When historical data are no longer a good predictor of future changes, the market basket methodology becomes ineffective. Indeed, using more recent data, the market basket inflation for FY 2022 was actually 5.5%, well above the 2.6% LTCH PPS market basket forecast that was used in FY 2022. Additionally, the latest data also indicate decreases in productivity, not gains.

Therefore, because the statute provides CMS with LTCH PPS oversight authority broader than the level granted for other Medicare payment systems, we urge CMS to use this authority to 1) implement an adjustment for FY 2024 to account for the

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[1] ATI Advisory, *Role of LTAC Hospitals in COVID-19 Pandemic*; Feb. 2021 (https://atiadvisory.com/wp-content/uploads/2021/02/Role-of-LTAC-Hospitals-in-COVID-19-Pandemic.pdf).

difference between the market basket update that was implemented for FY 2022 and what the market basket is currently projected to be for FY 2022, and 2) eliminate the productivity cut for FY 2024.

CMS has unique and extensive oversight authority of the LTCH PPS. In multiple rules over the years, the agency has cited its "broad authority under section 123 of the BBRA as amended by section 307(b)(1) of the BIPA to determine appropriate adjustments under the LTCH PPS, including whether (and how) to provide for adjustments to reflect variations in the necessary costs of treatment among LTCHs."[2] Indeed, Congress specifically granted CMS the statutory authority to adjust the LTCH PPS. Section 123 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), as amended by section 307(b)(1) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, states that "[t]he Secretary shall examine and may provide for appropriate adjustments to the long-term hospital payment system, including adjustments to DRG weights, area wage adjustments, geographic reclassification, outliers, updates, and a disproportionate share adjustment…"[3]

CMS has frequently used this authority to establish payment adjustment policies in the LTCH PPS, including to adjust for high-cost outliers,[4] short stay outliers,[5] and area wage levels.[6] In fact, this FY 2024 proposed rule cites the agency's "broad authority" for LTCH PPS payment adjustments for multiple aspects of this year's payment adjustments. We urge CMS to use this same authority to support stability for the LTCH field as it continues to respond to the unusual and extreme circumstances wrought by the PHE.

Financial and Clinical Context

While the PHE has technically ended, LTCHs continue to face very real difficulties and uncertainties due to the pandemic and its aftereffects. Most relevant is that hospitals, including LTCHs, have been facing unprecedented inflation. The most recent analysis from Kaufman Hall in its *National Hospital Flash Report* indicates that from 2020 to

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[2] RY 2008 LTCH PPS Final Rule, 72 Fed. Reg. 26870, 26900 (May 11, 2007); also RY 2006 LTCH PPS Final Rule, 70 Fed. Reg. 24168, 24199 (May 6, 2005) ("[W]e have broad authority under section 123 of Pub. L. 106-113, including whether (and how) to provide for adjustments to reflect variations in the necessary costs of treatment amount LTCHs").
[3] Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. No. 106-554, § 307(b)(1), 114 Stat. 276 (2000).
[4] FY 2015 IPPS/LTCH PPS, 79 Fed. Reg. 49854, 50398 (Aug. 22, 2014) ("Under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of the BIPA, in the regulations at § 412.525(a), we established an adjustment for additional payments for outlier cases that have extraordinarily high costs relative to the costs of most discharges.").
[5] 70 Fed. Reg. at 24197.
[6] 79 Fed. Reg. at 50392 ("Under the authority of section 123 of the BBRA, as amended by section 307(b) of the BIPA, we established an adjustment to the LTCH PPS standard Federal rate to account for differences in LTCH area wage levels . . . .").

present, overall expenses have risen by 18% for hospitals.[7] This has been driven in large part by labor costs, including contract labor costs, which have risen 258% since 2019.[8] This inflation is felt sharply by LTCHs, which care for some of the most critically ill patients with lengths of stay averaging at least 25 days, and who require labor-intensive care and a wide range of specialty drugs and devices. Indeed, inflationary and labor pressures on LTCHs and other hospitals will continue, with the Department of Health and Human Services (HHS) finding that health care workforce shortages will persist well into the future.[9]

Labor is not the only expense experiencing large growth in recent years. Hospital supply costs per patient have risen 18.5% between 2019 and 2022.[10] Drugs, and especially specialized drugs, make up a large portion of this increase, with an HHS study finding that many commonly used drugs have had their price increase by more than 30% in recent years.[11] And, unfortunately, these financial pressures also impact LTCHs' short-term hospital partners. A December 2022 AHA study revealed an 11.1% increase in the average length of stay of hospital patients awaiting discharge to a LTCHs since 2019.[12] Therefore, as CMS considers the impact on adequate reimbursement for LTCHs, it should be mindful of the upstream effects LTCHs have on short-term hospitals.

There are also challenges that are particularly unique to LTCHs. As CMS knows, through the PHE and until last month, LTCHs were paid the full standard LTCH PPS rate for all discharges. In addition, during the same period, the LTCH "50 percent rule" was waived. Despite these waivers and the financial challenges facing hospitals, LTCHs have cared for sicker patients with longer lengths of stay during the pandemic.

LTCHs and their acute-care partners are now working to adjust to the expiration of these waivers, which requires reevaluating referral and admission determinations to ensure hospitals can maintain their LTCH status, as well ensure reimbursement is adequate to support continuing operations. Indeed, the site-neutral criteria has already proven difficult for LTCHs, with more than 20% of all LTCHs closing since the criteria was phased in beginning in FY 2016. Without adequate reimbursement, the ability of

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[7] Kaufman Hall | *National Hospital Flash Report* (April 2023) https://www.kaufmanhall.com/sites/default/files/2023-05/KH-NHFR_2023-04.pdf
[8] Syntellis and AHA, *Hospital Vitals: Financial and Operational Trends* at 2 (last visited May 8, 2023), https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2_Feb%202023.pdf.
[9] ASPE Office of Health Policy, *Impact of the COVID-19 Pandemic on the Hospital and Outpatient Clinician Workforce*, HP-2022-13 at 1 (May 3, 2022).
[10] American Hospital Association, Cost of Caring at 4 (Apr. 2023), https://www.aha.org/costsofcaring.
[11] Arielle Bosworth, et al., Assistant Secretary for Planning and Evaluation, *Price Increases for Prescription Drugs*, 2016-2022, HP-2022-27 at 1 (Sep. 30, 2022), https://aspe.hhs.gov/sites/default/files/documents/d850985c20de42de984942c2d8e24341/price-tracking-brief.pdf.
[12] AHA, Issue Brief: *Patients and Providers Faced with Increasing Delays in Timely Discharges*; December 2022 (https://www.aha.org/system/files/media/file/2022/12/Issue-Brief-Patients-and-Providers-Faced-with-Increasing-Delays-in-Timely-Discharges.pdf).

LTCHs to continue caring for their patients will be jeopardized, potentially putting the burden back on acute-care hospitals who are facing their own challenges.

Market Basket

Despite these enormous and ongoing challenges for LTCHs, CMS' annual market basket updates have been inadequate to meet these rising costs. For FY 2024, the agency proposes a market basket update of only 3.1%. In FYs 2022 and 2023, it provided only 2.6% and 4.1% market basket increases, respectively. Yet, the agency's own, most recent data show that the actual inflation figures for FY 2022 and FY 2023 were 5.5% and 4.6%, respectively. This means that in the last two years alone, CMS has enacted what amounts to a 3.4% reduction in pay relative to actual market basket inflation. **Given these extreme and uncontrollable circumstances, we strongly urge CMS to use its statutory authority over the LTCH PPS to implement an adjustment that at a minimum accounts for the difference between the market basket adjustment that was implemented for FY 2022 and what the market basket is currently projected to be for FY 2022 and add that adjustment to the FY 2024 update.** However, given the additional inflationary pressures facing hospitals, CMS should consider further upward adjustments.

Productivity Factor

Contributing to these underpayments is CMS' application of a productivity factor adjustment to yearly market basket updates. Under the Affordable Care Act, the LTCH payment update is reduced annually by a productivity factor, which is equal to the 10-year moving average of changes in the annual economy-wide, private nonfarm business total factor productivity (TFP).[13] This measure was intended to ensure payments more accurately reflect the true cost of providing patient care. For FY 2024, CMS proposes a productivity cut of 0.2 percentage points.

The use of the private nonfarm business TFP is meant to capture gains from new technologies, economies of scale, business acumen, managerial skills and changes in production. Thus, this measure effectively assumes that LTCHs can mirror productivity gains across the private nonfarm business sector. However, in an economy marked by great uncertainty due to inflation as well as demand and supply shocks, this assumption generates significant departures from economic reality. In fact, CMS itself has acknowledged that hospitals are unable to achieve the productivity gains assumed by the general economy over the long run. Specifically, research indicates that hospitals can only achieve a productivity gain that is one-third of the gains seen in the private nonfarm business sector.[14] Thus, using the private nonfarm business sector TFP to

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[13] Centers for Medicare and Medicaid Services. (February 2016). Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends- and-Reports/ReportsTrustFunds/Downloads/ProductivityMemo2016.pdf
[14] *Id.*

adjust the market basket exacerbates Medicare underpayments to hospitals – particularly in a period of record inflation.

In addition, whereas the private nonfarm business economy experienced a rapid increase in output and productivity gains when communities began emerging from COVID-19 lockdowns in late 2021, the same has not been true for hospital services. Generally, hospital services have not recovered to pre-pandemic levels, and it is highly unlikely that hospitals have achieved the significant productivity gains incorporated into the proposed FY 2024 payment update. Specifically, Bureau of Labor Statistics data show that hospital employment levels have decreased by approximately 100,000 from pre-pandemic levels.[15] Further, the combination of employee burnout and fewer available staff have forced hospitals to rely heavily on contract staff, especially contract nurses. The loss of established employees and the reliance on contract staffing firms to help address staffing shortages all echo our members' experiences related to declines in productivity during the pandemic, not gains.

The AHA has deep concerns about the proposed productivity cut, given the extreme and uncontrollable circumstances in which hospitals and health systems are currently operating. As such, we ask CMS to use its existing statutory authority over the LTCH PPS to eliminate the proposed productivity cut for FY 2024. It is clear that significant uncertainty will continue to persist regarding the direction and magnitude of U.S. economic performance as inflationary pressures caused by multiple factors (such as fiscal and monetary policy, supply chain disruptions and the war in Ukraine) continue to affect productivity. This uncertainty, as well as the continued divergence in hospital productivity from overall private nonfarm business sector productivity, must be accounted for in the FY 2024 payment update.

Proposed High-Cost Outlier Payments for LTCH PPS Standard Federal Payment Rate Cases

As part of the standard rate LTCH PPS, Medicare makes additional payments for HCO cases that have high costs relative to typical discharges. CMS sets a fixed-loss amount for HCOs, which is an amount by which costs must exceed reimbursement in order for a claim to be paid a high cost outlier adjustment. CMS sets the HCO fixed-loss amount by projecting what it would need to be for 7.975% of total LTCH PPS payments to be HCO payments. For FY 2024, CMS is proposing to increase the HCO fixed-loss amount from $38,518 to $94,378, a staggering 150% increase.

We are concerned that the data used to project the fixed-loss threshold is not representative of what we can expect to see in FY 2024 because of the unique

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[15] American Hospitals Association. (April 2022). *Massive Growth in Expenses and Rising Inflation Fuel Continued Financial Challenges for America's Hospitals and Health Systems*. https://www.aha.org/costsofcaring

circumstances facing LTCHs and their short-term acute-care partners throughout the pandemic. The resulting proposed amount of $94,378 is simply untenable for LTCHs – most cannot afford to absorb anywhere near this amount of financial loss. Such a threshold would result in severe restrictions in access for the most critically-ill Medicare beneficiaries; it would be devastating to LTCHs' ability to care for the sickest of the sick, which is a patient population they take on at what is sometimes already a considerable financial loss. **For these reasons, AHA *greatly* appreciates the fact that CMS requested feedback on its proposal and methodology.**

Below, we provide alternative proposals for calculating the outlier threshold. Each would produce more appropriate outlier projections for FY 2024. Overall, however, we do not believe that trends from the FY 2022 claims data (which were used to calculate the proposed threshold) will continue; therefore, CMS can reasonably make more conservative assumptions about growth that would then result in lower fixed-loss amounts. Specifically, for reasons elaborated on below, the tumultuous circumstances that LTCHs and other providers have faced skewed the FY 2022 data for LTCH charges and claims, but CMS can expect several transitions in FY 2023 that will see LTCH claims and charge data stabilize.

Alternative #1: Use more recent data to calculate charge inflation factor and account for health system capacity issues.
CMS determined the charge inflation factor (CIF) that it used in calculating the proposed outlier threshold by dividing the average covered charge per case from FY 2022 claims by the average covered charge per case from FY 2021 claims. This is done to give CMS an estimate of the rate by which charges might rise in FY 2023 and FY 2024. CMS used the December 2022 update of the FY 2022 MedPAR file and the December 2021 update of the FY 2021 MedPAR data as the basis for this calculation, which resulted in a one-year CIF of 13.56%. However, we analyzed claims data from the first six months of FY 2023 – Oct. 2022 through March 2023.[16] **AHA's analysis found that when these data from the first half of FY 2023 were compared to data from FY 2022, the average covered charge per case rose only 2.5%.[17]**

We urge CMS to rely on these more recent FY 2023 data in determining the CIF for numerous reasons. In addition, in analyzing past CIF trends, we found that the inflation in the first half of the year was largely equal to the inflation of the entire year. **Therefore, we more specifically urge CMS to calculate the CIF as 2.5% squared, or**

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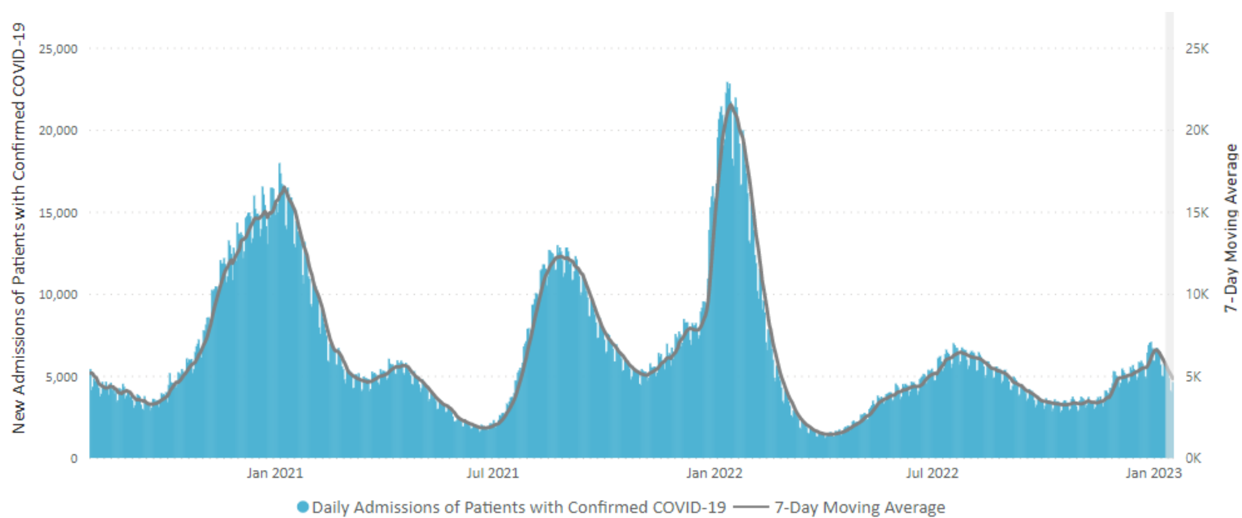
[16] Analysis by Dobson DaVanzo and Associates LLC of Medicare fee-for-service inpatient claims data, CMS Chronic Conditions Warehouse Virtual Data Research Center, under DUA #54757.
[17] This figure was reached using the same methodology adopted by CMS in its calculation of the CIF. This included identifying LTCH PPS standard federal payment rate cases (fee-for-service only), excluding all-inclusive rate providers, excluding claims from providers that only had claims in one of the fiscal years, excluding provider 312024, removing statistical outliers based on growth in average charges and removing claims with no covered charges.

5.0625%, which would appropriately inflate the FY 2022 claims data to project FY 2024 projections.

First, and perhaps most importantly, using these data are consistent with CMS' commitment to using the most recently available data. We share this commitment, particularly in a case such as this where it is demonstrated that the inflationary trend of 13.56% has not continued. In addition, using these data would be consistent with CMS' previous finding that the PHE time-period data are aberrant and should not always be relied upon. For example, for FY 2023, CMS used a blended approach by averaging the fixed-loss amounts both with and without COVID-19 cases. More on point, CMS used the CIF from the pre-PHE time period by comparing 2018 and 2019 data for setting the FY 2023 fixed-loss threshold. CMS had sound justification for these modifications; indeed, there is similar sound justification for modifying FY 2024 outlier calculations, which rely upon FY 2022 data. Specifically, as shown below, the largest surge of COVID-19 hospitalizations occurred in FY 2022, with numerous additional surges occurring throughout the remainder of the year.



Source: https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/01202023/images/hospitalizations.PNG?_=24630

It's clear that FY 2022 was a time in which hospitals, particularly LTCHs, were strained by the pandemic. In fact, CMS acknowledged in last year's proposed rule that it "believe[s] this abnormally high charge inflation factor is partially due to the high number of COVID-19 cases that were treated in LTCHs in FY 2021."[18] The agency was correct in its belief at the time, and therefore should account for this effect in its policymaking this year as well. Doing so would be both consistent with past policy and conducive to producing more stable results for beneficiaries and providers.

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[18] *87 Fed. Reg. at 28,690.*

In addition to utilizing more recent data, we urge CMS to account for another fundamental change that occurred during the PHE; the waiver of the site neutral payment policy. As CMS knows, LTCHs were paid at the full payment rate throughout the PHE, regardless of whether the patient met the criteria for the standard payment rate. In addition, many acute-care hospitals were operating beyond capacity and could not always offer an ICU placement to critical patients for a full three days; patients may have instead moved to a step-down or remained in a medical-surgical bed. These were necessary steps given the extreme shortages of ICU and other hospital capacity.

Indeed, evidence of this is reported by our members: many report that despite not changing their own admission criteria and process (based on clinical characteristics), their percentage of site-neutral cases rose significantly during COVID-19 surges, including in FY 2022. What this means is that CMS should expect that many patients classified as site-neutral in FY 2022 were actually and would be criteria compliant patients in FY 2024.

AHA therefore strongly recommends that CMS include all site neutral claims when calculating the fixed-loss threshold. Doing this will ensure CMS uses the data that includes many claim types that will be classified as the standard LTCH PPS payment amount in FY 2024. This, combined with using the CIF derived from FY 2023 data, would yield a fixed-loss threshold of $29,364, a more accurate and appropriate target.

In addition to accounting for site neutral patients, LTCHs have also identified another specific trend that we urge CMS to consider accounting for – the increasing challenges in caring for dialysis patients. As previously mentioned, all providers have faced unprecedented cost increases and labor-shortages. For LTCHs, this has made it increasingly difficult to safely discharge dialysis patients into outpatient dialysis care. In FY 2022, dialysis treatment facilities and home care providers were unable to meet demand due to staff shortages and the additional time and resources needed for COVID-19 safety precautions. This is especially true for LTCH patients, who typically have multiple co-morbidities and are more complex and resource-intensive than other types of dialysis patients.

As a result, LTCHs have kept dialysis patients in their hospitals for much longer time periods than usual, driving up lengths of stay and resulting charges. They have been working with community partners and believe that the obstacles are abating. But, this is nonetheless something that must be accounted for when using FY 2022 data. **More specifically, we urge CMS to consider excluding these dialysis claims when calculating the fixed-loss threshold.** This can be done by identifying cases using dialysis procedure codes such as 5A1D70Z, 5A1D80Z, 5A1D90Z and 3E1M39Z. Again, this would be consistent with CMS' past practice of excluding certain claims due to the effects of the pandemic.

We believe these are appropriate methodological changes based on proven trends and reasonable assumptions about what the forthcoming FY 2024 claims and charges will look like. AHA would be pleased to provide CMS the underlying analysis and data used for these simulated methodologies if it would be helpful to the agency.

Alternative #2: Use a market basket-based CIF and account for health system capacity issues.
Prior to FY 2022, CMS used a different methodology to calculate the CIF. More specifically, CMS calculated the CIF by inflating charges by a growth factor calculated from quarterly market basket values. When the agency proposed to change to its current claims-based CIF methodology, the field warned that making such significant changes in the middle of such a turbulent time was ill-advised. It was unclear why CMS would make such a change after nearly 20 years of using a market basket-based CIF, and the field pointed out using a market basket-based CIF would ensure more stability for providers.

However, CMS moved forward with its change, and we now see a proposed CIF that is leading to the proposed 150% increase in the outlier threshold. **Therefore, if CMS does not wish to adopt our preferred FY 2023-based CIF described above, we urge it to revert to its prior market basket-based CIF methodology.** This methodology produces a two-year CIF of 7.8%, a more reasonable and stable figure. It also relies on data that CMS already relies upon for the annual payment update to the LTCH PPS, and its numerous other payment systems.

When utilizing this market basket-based CIF and including site-neutral patients (as we urge CMS to do), AHA calculated a fixed-loss amount of $33,549.[19] We also again urge CMS to consider excluding dialysis patients. These would be appropriate changes to make given the abnormal circumstances in place in FY 2022. They would also yield a reasonable threshold that would not be disruptive to beneficiary access.

Alternative #3: Use pre-pandemic data as the health care system transitions out of the PHE.
As previously mentioned, CMS deviated from its typical methodology for both HCOs and other LTCH PPS payment dynamics during the COVID-19 PHE. For FY 2023, CMS explored calculating the CIF by using pre-pandemic data. More specifically, it stated that "[w]e also believe there will be fewer COVID-19 cases in FY 2023 than in FY 2021 and therefore do not believe it is reasonable to assume charges will continue to increase at this abnormally high rate."[20] We believe this rationale is even more applicable to setting outlier thresholds for FY 2024.

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[19] This figure we calculated by using data from the proposed rule. We understand updated data may change this figure in the final rule, but AHA believes the methodology is sound and would produce an equitable figure.
[20] 87 Fed. Reg. at 28,690,

As stated earlier, the country's health care system is transitioning out of the PHE. While many challenges remain, FY 2024 in many ways will mark the transition back to as close to pre-pandemic care patterns as is possible. Among other examples, LTCHs are transitioning back to their prior admissions practices due to the expiration of the site-neutral payment and 50-percent rule waivers. In addition, strain on other settings such as acute-care hospitals and outpatient care (including dialysis centers) will begin to relent. As such, it would be reasonable to assume that patient care will more closely resemble the pre-PHE time period. Therefore, if CMS does not wish to adopt the alternatives above, we recommend that it utilize FY 2019 data in calculating the outlier threshold, keeping all other portions of the methodology (including the proposed CIF of 28.9703%) as proposed. According to our calculations, this would produce a fixed-loss threshold of approximately $37,589 – again a more reasonable threshold that would not be disruptive to beneficiary access.

LTCH Quality Reporting Program (IRF QRP)

The Affordable Care Act mandated that reporting of quality measures for LTCHs begin no later than FY 2014. The Improving Medicare Post-Acute Care Transformation (IMPACT) Act requires that, starting FY 2019, providers must report standardized patient assessment data elements and quality measures as part of the QRP. Failure to comply with LTCH QRP requirements will result in a 2.0 percentage point reduction to the LTCH's annual market-basket update. For FY 2024, CMS requires the reporting of 18 quality measures by LTCHs.

CMS proposes to adopt two new measures as well as a modified version of an existing measure while removing three measures. CMS also proposes to begin public reporting for four measures. Finally, CMS proposes to increase the data completeness threshold for LTCH assessments.

Modified COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) Measure

Beginning with the FY 2025 LTCH QRP, CMS would adopt a modified version of the COVID-19 Vaccination Coverage among HCP currently used in the LTCH QRP. While the current measure assesses the number of HCP "who have received a complete vaccination course against COVID-19," CMS would replace this term with "who are up to date" with their vaccination as recommended by the Centers for Disease Control and Prevention (CDC) at the time of the reporting period.

The AHA strongly supports the vaccination of health care personnel and communities against COVID-19. We also agree with CMS' rationale underlying the proposal to adopt this modified measure that measures in use in its quality reporting programs should reflect the current science.

However, the evidence around the optimal cadence for booster doses of COVID-19 vaccination, as well as the seasonality of the virus itself, is evolving rapidly. Over the past several months, CDC and FDA have indicated they are seriously considering the adoption of a once-yearly regimen for COVID-19 vaccinations comparable to the well-established approach used for influenza vaccination. In addition, the AHA is concerned that the administrative complexity of collecting CDC's current definition of "up-to-date" status may outweigh its benefit. For these reasons, **we recommend CMS continue to collect up-to-date vaccination status on a voluntary basis, and implement required reporting of up-to-date status after FDA and CDC have completed their recommendations on an updated vaccination schedule.**

We encourage CMS to learn from the experience of implementing the previous version of this measure and take into account the foreseeable logistical challenges of data collection and reporting when considering this new version for inclusion in its various quality reporting programs. As CMS notes in the proposed rule, health care facilities are collecting and reporting data on "up-to-date" COVID-19 vaccination status on a voluntary basis. However, facilities have reported that this collection process is quite administratively burdensome under CDC's current "up-to-date" definition. This is because the collection protocol uses a reference time-period for determining up-to-date status that changes every quarter. Practically speaking, this means that a HCP who counted as "up-to-date" in a given quarter may no longer be up-to-date in the next quarter. Furthermore, CDC's vaccination guidance suggests that some individuals with certain risk factors should consider receiving an additional booster dose within four months of receiving their first bivalent dose. Yet, hospitals usually do not have routine access to data to know which of their HCP's may need an additional booster. In fact, collecting accurate data on HCPs underlying risk factors likely would require hospitals to both obtain permission to have such data, and a mechanism to keep the data fully secure. The AHA is concerned that the resource intensiveness of collecting data under CDC's current definitions may outweigh its value.

The AHA believes that the adoption of a once-yearly vaccination regime would alleviate much of the administrative complexity of collecting up-to-date vaccination status. While we do not yet know the precise timing, recent discussions from the FDA and CDC's vaccination advisory committees, as well as public statements from the agencies and White House, suggests that such a schedule could be adopted as soon as Fall 2023. By delaying the required reporting of "up-to-date" vaccination status, CMS could align its reporting requirements around this more efficient approach. In practical terms, we believe the soonest facilities could report up-to-date status based on a once-yearly vaccination regimen is the second quarter of 2024, but we recognize that more time may be needed.

As CMS continues to implement the HCP COVID-19 vaccination measure across its programs, we also urge it to consider other important implementation issues. For example, we continue to urge that CMS get the measure endorsed by a consensus-based entity (CBE). A CBE endorsement process will enable a full evaluation of a range

of issues affecting measure reliability, accuracy and feasibility. Given the urgency of addressing the COVID-19 pandemic, the current version of the measure never went through a CBE endorsement process and is relatively new to the CMS quality reporting programs. As a result, we have not yet had a holistic evaluation regarding whether the measure is working as intended (e.g., reflecting vaccination rates accurately, achieving CMS' stated goals of encouraging vaccination).

Finally, CMS needs to consider how to implement this measure in a way that is consistent and logical with other sources of information regarding vaccination among healthcare personnel. The time lag between data collection and the publicly reported rate will result in a mismatch between the true rate of healthcare personnel who are up-to-date with their vaccinations and the rate that is displayed on Care Compare; CMS needs to clearly communicate what publicly reported data reflects.

Discharge Function Score Measure

Beginning with the FY 2025 LTCH QRP, CMS proposes to adopt this assessment-based outcome measure that estimates the percentage of LTCH patients who meet or exceed an expected discharge score during the reporting period. The agency issues the same proposals for the Skilled Nursing Facility (SNF) and Inpatient Rehabilitation Facility (IRF) QRPs as well in their respective rules, terming the measure a "cross-setting" measure.

While this cross-setting discharge function score measure appears to fulfill requirements of the IMPACT Act better than the current, setting-specific self-care and mobility discharge score measures used in the SNF, LTCH and IRF quality reporting programs (which CMS proposes to remove in this same rule), we continue to doubt the cross-setting applicability of this measure considering the different patient populations served by the various post-acute care settings. **We urge CMS to wait until this measure has undergone endorsement review by a consensus-based entity (CBE) and demonstrates that it gleans useful information for patients and providers before adopting it for use in the LTCH QRP.**

The measure uses information from Section GG items that appear on all four of the patient assessment instruments across the various post-acute care settings. While patients are assessed using the same or similar items, the capabilities and goals of patients differ widely by setting. The measure developer notes that the measure is risk adjusted and calculated individually by setting; then, the calculation for measure performance "rolls up" information from several items to calculate an overarching score. Risk adjustment takes many variables into account, and denominators vary by setting (for example, the denominator for the measure when calculated in the IRF and LTCH QRPs includes all eligible stays, regardless of payer, while for the SNF QRP the denominator consists of patients/residents under Medicare fee-for-service only).

While we appreciate the work the developer has done to attempt to take into account the myriad of differences in patient populations across the various settings—including demographics, case mix, severity of illness, length of stay, and comorbidities—at some point these variables alter the underlying calculation of the cross-setting measure and result in four different measures—in other words, discharge function is calculated in a way that is not truly standardized, as the IMPACT Act intended. It is at this point we ask whether it is necessary to force a measure that is "cross-setting" in name only into CMS quality programs; perhaps if testing of the measure demonstrates that this measure produces statistically meaningful information that can be used to inform improvements in care processes, it is. But until we have that information from the endorsement review process by a CBE, the AHA has serious doubts about the utility of this measure.

In addition, the measure uses a statistical imputation approach to account for "missing" assessment elements when codes on the assessments note that the "activity was not attempted" (ANA). In the event that an assessor codes an item as "not attempted," the imputation approach inserts variables based on the values of other activities that were completed; in other words, the calculation makes assumptions about what the patient would have scored on that item if it had been attempted based on their performance on other, similar activities that were. CMS argues that this approach "increases precision and accuracy and reduces the bias in estimates of missing item values." While we understand that scores would be influenced more heavily by individual assessment items if there are fewer included in the calculation, CMS errs in labeling items coded ANA as "missing." When an activity is not attempted, it is likely because it would be clinically inappropriate or dangerous for a patient to attempt it; for example, it would be ill-advised (and painful) for a patient with a healing wound on one side to roll left to right. In such a case, making assumptions about the patient's function based on other activities would, in fact, not improve the precision of the score.

We also question whether it is precise and accurate to generically apply an "expected" discharge score based on statistical regressions to unique patient populations, and whether the comparison of observed to "expected" function could wholly be attributed to the facility's quality of care. The calculation approach for the "expected" discharge score is opaque, which makes it difficult for providers to know what they're working towards. In reality, providers strive to help each individual person achieve his or her own specific goals related to function, independence, and overall health. These goals are not based on statistical regressions.

The AHA understands the purpose of this measure and agrees that the discharge function measures currently in use in the LTCH QRP (Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan and Application of Percent of Long-term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function) do not meaningfully evaluate comparative performance across post-acute care settings. However, **we argue that it is inappropriate to implement a "standardized" measure on function when improved function upon discharge is not the primary goal of**

critically ill LTCH patients. Due to these issues, we do not believe that this measure brings value to the LTCH QRP and thus cannot support it for adoption.

Patients/Residents who are Up to Date with COVID-19 Vaccination Measure

Beginning with the FY 2026 LTCH QRP, CMS proposes to adopt this assessment-based process measure that reports the percentage of stays in which patients in an LTCH are up-to-date with their COVID-19 vaccinations per the CDC's latest guidance. The agency reasons that the measure would, when publicly reported, provide useful information for patients and their caregivers when choosing a facility, and "would be an indirect measure of LTCH action" since the LTCH would, according to CMS, have the opportunity to administer the vaccine to patients during their stay, coordinate a follow-up visit for the patient to obtain the vaccine at their physician's office or local pharmacy, or educate the patient about the importance of staying up-to-date with vaccinations. CMS also proposes to adopt this measure for the SNF and IRF QRPs in their respective rules.

The AHA strongly supports the vaccination of health care providers and communities for COVID-19, and acknowledges the importance of up-to-date vaccinations. However, this measure has not been tested for validity and reliability and thus we cannot support it without knowing that it is, at minimum, feasible to report and likely to produce statistically meaningful information. Furthermore, we are not clear that the conceptual construction of the measure is the best way to encourage vaccination, especially in post-acute settings where care is delivered in episodic rather than longitudinal fashion. When reviewed by the National Quality Forum (NQF)'s Measure Applications Partnership (MAP) during the 2022-2023 review cycle, the Post-acute/Long-term Care Workgroup voted "Do Not Support" for this measure, meaning that a multi-stakeholder panel of experts representing providers, patients and payers do not support this measure for inclusion in the LTCH QRP.

Vaccination status among patients/residents is subject to many patient-level factors outside of the control of providers. For post-acute facilities and providers, it may be infeasible or inappropriate to offer vaccination for patients due to length of stay, ability to manage side effects and medical contraindications, or other logistical challenges to gathering information from a patient who may have received care from multiple proximal providers. Even without these challenges, however, patients/residents may choose to forgo vaccination despite a provider's best efforts. It is possible that a post-acute care facility could have a robust effort to encourage vaccination among their patients/residents, but still have a relatively low rate of vaccination. As the Health Equity subcommittee of the NQF MAP noted in its review of this measure, cultural norms often play a large role in vaccine confidence. While post-acute providers will always seek to counsel vaccination in a culturally sensitive way, they also want to honor the choice of their patients once they have offered their clinical advice.

We reiterate that we understand the importance of vaccination in protecting patients

from the most serious outcomes of COVID-19. However, it is unclear whether the use of this measure will produce those results or if it is feasible for post-acute care facilities to collect and report the information necessary. The measure consists of a single yes or no item on the LCDS without any requirements for documentation or validation of vaccination status; while we acknowledge that additional documentation would be unduly burdensome for providers to collect, without it the measure is a mere checkmark in a box with no evidence that it leads to improved quality of care (since, as stated above, the measure has not been fully tested). For these reasons, **we do not support the adoption of this measure in the LTCH QRP.** CMS also may want to consider whether alternative measure constructions focused on the actions providers take in encouraging vaccination might be better suited to achieving the goal of higher vaccination rates.

Increase in Data Completion Threshold

Beginning with the FY 2026 LTCH QRP, CMS proposes to require LTCHs to report 100% of the required quality measure data and standardized assessment data collected using the LCDS tool on at least 90% of assessments submitted to CMS, an increase from the current threshold of 80%. If LTCH do not meet this requirement, they would be subject to the 2 percentage point reduction to their application FY annual payment update. CMS reasons that it needs more complete data to ensure the validity and reliability of the LTCH QRP, and states that its data shows that the majority of LTCHs area already meeting or exceeding the proposed threshold.

While we understand CMS' desire to have "more complete data," we do not believe that this proposal will achieve that objective. First, the idea behind allowing for 20% of the assessments to be incomplete is to accommodate those instances in which it is not possible to complete the assessment for clinical reasons, such as when patients are discharged or transferred to an acute care hospital under emergency circumstances. In such cases, it would be inappropriate to stop the emergency discharge or transfer process to undertake a skin assessment of the patient, for example, and the assessment would be deemed incomplete. For facilities that serve larger proportions of complex and/or acutely ill patients, these cases are more frequent and that 20% buffer is necessary. Increasing the threshold to 90% would put these facilities that have otherwise been in compliance with the reporting requirements at a serious disadvantage.

Second, CMS argues that its proposal would not be overly burdensome to providers because so many of them already meet or exceed the 90% threshold. These providers clearly do not need the motivation of a higher threshold to report a larger proportion of complete assessments, so CMS' proposal would be moot. For those who are reporting at least 80% complete assessments, the increased threshold would put unnecessary pressure to complete the extremely lengthy and time-consuming LCDS, potentially negatively affecting the accuracy of the data—using the same example of the patient being emergently transferred to acute care, an assessor might feel the need to perform

a cursory skin assessment just to reach the completion threshold (while simultaneously attempting not to slow down the transfer to acute care).

For these reasons, we do not support the proposed increase in data completion threshold from 80% to 90%. Doing so would solely disadvantage providers who care for complex patients and would not provide any additional incentive for others to report better data.

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We appreciate your consideration of these issues. Please contact me if you have questions or feel free to have a member of your team contact Jonathan Gold, AHA's senior associate director for policy, at (202) 626-2368 or jgold@aha.org.

Sincerely,

/s/

Stacey Hughes
Executive Vice President, Government Relations and Public Policy