June 16, 2015

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

Field Electronically
Attention: CMS-1632-P

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

Dear Mr. Slavitt:

This letter is respectfully submitted on behalf of the Kentucky Hospital Association (KHA) member hospitals, including seven long-term acute care hospitals (LTCHs) located in Kentucky which provide specialized programs of care to chronically and critically ill and medically complex patients who are Medicare beneficiaries. KHA appreciates the opportunity to share our comments on the Centers for Medicare & Medicaid Services’ (CMS) fiscal year (FY) 2016 proposed rule for the inpatient and LTCH prospective payment systems (PPS).

This letter addresses the proposed criteria for the standard LTCH PPS rate, the proposed implementation of LTCH site-neutral payments and the proposed additions of the LTCH quality reporting program (QRP). Separate are KHA’s comments on the agency’s inpatient PPS proposals.

**PROPOSED CRITERIA FOR STANDARD LTCH PPS RATE**

The rule proposes implementation of the Bipartisan Budget Act of 2013 (BiBA) requirement to add a site-neutral payment component to the LTCH PPS for cost reporting periods beginning on or after October 1, 2015. This change represents a major transformation of the LTCH PPS. Under BiBA’s new dual-rate system for LTCHs, certain qualifying cases will be paid the traditional LTCH PPS rate, while others will be paid a lower site-neutral rate based on an inpatient PPS rate.

As required by BiBA, this rule proposes to transition LTCHs to a dual-rate structure that pays for LTCH services using two sets of rates — standard LTCH PPS rates and lower, site-neutral rates.

**Proposed Criteria for Cases Paid a Standard LTCH PPS Rate**

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.

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

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 Discharges
CMS proposes that to be considered “immediately discharged” a beneficiary must be admitted to an LTCH within one day of discharge from a general-acute care hospital. In addition, CMS proposes to require that a beneficiary have an inpatient PPS claim discharge status code of 63 or 91, which indicates discharge to an LTCH. If during the one-day transition to an LTCH, a patient received home care or services in an inpatient rehabilitation, inpatient psychiatric or skilled nursing facility, the case would be ineligible for the standard LTCH PPS rate.

CMS’s stated purpose for requiring discharge codes 63 or 91 is to try to ensure that the transferring patient did not receive another service between inpatient PPS discharge and LTCH admission. However, Dobson-DaVanzo’s analysis of cases that transfer to an LTCH (2013 SAF data set) indicates that any such interim services are rare, because 99.4 percent of LTCH admissions occur on the same day as the inpatient PPS discharge. Regarding the remaining 0.6 percent of cases, they are admitted to an LTCH one day following inpatient PPS discharge.

KHA agrees with CMS that many of these are cases were likely discharged before midnight, but not officially admitted to the LTCH until just after midnight. Thus, the agency’s concern about other services being provided between inpatient PPS discharge and LTCH admission is unwarranted and should be withdrawn as the rationale for requiring discharge codes 63 and 91. Instead, CMS should use only a single criterion to define an immediate discharge – that a case must be transferred from an inpatient PPS hospital to an LTCH within one day.

The rule also 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) – would not invalidate an LTCH case
that is otherwise considered to have been “immediately discharged” from a general acute-care hospital to an LTCH.

The KHA opposes the proposed use of inpatient PPS discharge status codes to, in part, identify cases that were immediately discharged from an inpatient PPS hospital to an LATCH. Reason being, PPS discharge status codes are highly unreliable\(^1\) and would result in the systematic undercounting of cases eligible for a standard LTCH PPS rate thus penalizing LTCHs for unintentional data inaccuracy.

**ICU/CCU Revenue Codes**

Because many general acute-care hospital coding practices indicate that hospitals use a wide array of coding approaches, as allowed under the Medicare guidelines, KHA supports CMS’ proposal to include the full set of 18 ICU (020x) and CCU (021x) revenue codes when assessing eligibility for a standard LTCH PPS rate.

**Ventilator Criterion**

KHA supports CMS proposal to use ICD-10 procedure code 5A1955Z, which indicates that a patient received greater than 96 consecutive hours of respiratory ventilation in a hospital, be used to identify cases qualifying for an LTCH PPS rate under the ventilator criterion. CMS notes that it selected this procedure code, rather than using MS-LTC-DRGs, to more closely align with the population of LTCH cases receiving 96+ hours of ventilator services. However, KHA is concerned that the proposed code would exclude some ventilator cases that should also qualify for a standard LTCH payment under this criterion. Specifically, patients who receive exactly 96 hours of ventilator services would not be captured under CMS’s proposed ventilator criterion – even though BiBA authorizes their eligibility for a standard LTCH PPS rate. Under ICD-10, cases receiving precisely 96 hours of ventilator services will have a different procedure code, ICD-10-PCS code 5A1945Z (24 – 96 hours of mechanical ventilator services). To address this inappropriate exclusion, we recommend that CMS expand the proposed ventilator criterion to include cases that have either ICD-10-PCS code 5A1955Z or meet both of the following criteria:

- ICD-10 code 5A1945Z (Continuous invasive mechanical ventilation, 24 – 96 consecutive hours); and
- One of the following six MS-LTC-DRGs:
  - MS-LTC-DRG 3: ECMO or trach w MV 96+ hrs or PDX exc face, mouth & neck w maj O.R.;
  - MS-LTC-DRG 4: Trach w MV 96+ hrs or PDX exc face, mouth & neck w/o maj O.R.;
  - MS-LTC-DRG 207: Respiratory system diagnosis w ventilator support 96+ hours;
  - MS-LTC-DRG 870: Septicemia or severe sepsis w MV 96+ hours;
  - MS-LTC-DRG 927: Extensive burns or full thickness burns w MV 96+ hrs w skin graft; and
  - MS-LTC-DRG 933: Extensive burns or full thickness burns w MV 96+ hrs w/o skin graft.

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

**MS-LTC-DRG Weights**

When establishing the FY 2016 relative weights for cases to be paid a standard LTCH PPS rate, CMS proposes to use only those cases in the FY 2014 MedPAR file that would have been paid the standard LTCH PPS rate. CMS would exclude from these calculations all site-neutral cases. The rule’s online addendum lists the

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\(^1\) AHA analysis of the 2013 standard analytical file (SAF) data set found that for same-day inpatient PPS-to-LTACH transfers, the inpatient PPS discharge codes were incorrect 15 percent of the time. For inpatient PPS-to-LTACH transfers on the day following inpatient PPS discharge, the discharge code was erroneous 38 percent of the time. In both cases, the most common error was that the prior inpatient PPS claim had a discharge status code for a skilled nursing or inpatient rehabilitation facility, instead of an LTACH.
proposed 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 250 “low-volume MS-LTC-DRGs” (those with fewer than 25 LTCH cases) for FY 2016 would be grouped into quintiles, with each quintile assigned a relative weight. The “no-volume MS-LTC-DRGs” would again be weighted based on other MS-LTC-DRGs that are clinically similar and have similar costliness.2

**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 proposed FY 2016 labor-related share is 62.2 percent, a slight decrease from 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**

Kentucky hospitals, despite being efficient providers with a lower average cost than most other states, receive lower payments than most other states due to the Medicare Wage Index. Medicare pays acute care hospitals (excluding critical access hospitals) a flat fee based on a patient’s diagnosis, or DRG (Diagnosis Related Group). A hospital’s DRG payment is the product of two components: (1) a standardized amount, or base rate, which is adjusted by the hospital’s area average wage level and (2) the DRG’s relative weight.

The base rate is intended to represent the cost of an average Medicare inpatient discharge. One standardized amount is applied to all hospitals paid under the DRG system within the 48 contiguous states. This payment system is known as the Inpatient Prospective Payment System (IPPS).

The hospital wage index is used to adjust the standardized amount for area differences in hospital wage levels to account for the local wage variation or cost of labor in the hospital’s area. It is intended to measure the average wage level for hospital workers in each Metropolitan Statistical Area (MSA) or rural area (comprised of counties that have not been assigned to an MSA), relative to the national average wage level.

Because Kentucky has a lower average wage level, hospitals in Kentucky historically have been paid less under the Medicare program than hospitals in adjacent states. Although Kentucky’s hospitals must compete regionally for skilled employees, Kentucky’s Medicare wage index for both urban and rural hospitals is lower than its regional counterparts. This situation is perpetuated because continued low payment negatively impacts hospitals’ ability to increase wages.

Kentucky’s rural hospitals are paid less than rural hospitals in five surrounding states, and Louisville hospitals, despite treating sicker Medicare patients, continue to be paid less than hospitals in Cincinnati, Indianapolis and Nashville.

The LTCH PPS wage index is computed using wage data from general acute-care hospitals, without adjustments for geographic reclassification. For FY 2016, CMS proposes to 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. The proposed FY 2016 wage index values also are provided on CMS’s webpage that supplements this rule.

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 proposes an area wage index budget-neutrality factor of 1.0001444.

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2 AHA noted that under the new dual-rate structure, the number of no-volume MS-LTC-DRGs would substantially increase: from 247 in FY 2015 to 343 in FY 2016.
Proposed Implementation of Site-Neutral Payments

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

Using information provided by CMS, the AHA estimates that 45 percent of LTCH cases in the FY 2014 claims data, or 60,710 cases, would have received the site-neutral rate. However, during the FY 2016 transition to the two-tiered system, AHA estimated that only approximately half of these cases will actually receive a site-neutral payment, as LTCH cost report start dates are spread across all 12 months. In addition, in FYs 2016 and 2017, cases paid under the LTCH site-neutral policy will receive a 50/50 blend of the standard LTCH PPS and site-neutral rates, referred to below as the “standard rate” portion and the “site-neutral” portion, respectively.

Calculation of the High-Cost Outlier Pool

The KHA opposes CMS’s proposal to apply extra budget neutrality adjustments (BNA) to both the site-neutral and standard rate portions of site-neutral payments. CMS estimates that for the FY 2014 cases that would have received a site-neutral payment, HCO payments for the site-neutral portion of the blended payment would be 2.3 percent of total LTCH PPS payments. These cases would be subject to the inpatient PPS fixed-loss amount of $24,485.

However, the proposed rule lends itself to many concerns, including:

- CMS calculation of the 2.3 percent estimate is not clearly outlined;
- CMS inappropriately applies duplicate outlier-related BNAs to both the standard rate and site-neutral portions of the blended payment; and
- CMS inappropriately utilizes both site-neutral and standard rate elements when calculating the site-neutral HCO pool.

CMS should supply stakeholders with a detailed articulation of the steps used to calculate the 2.3 percent BNA. The application of this 2.3 percent BNA is unnecessary and inappropriately lowers LTCH payments.

Duplicate BNAs Are Unwarranted and Result in Inappropriately Low-payment Rates

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

CMS also proposes two outlier-related BNAs for site-neutral rates. Specifically, the inpatient PPS rates used as the basis for site-neutral payment rates are already subject to a BNA for the inpatient PPS’s 5.1 percent outlier pool. However, within the LTCH payment framework, CMS proposes a second BNA of 2.3 percent for the site-neutral outlier pool. CMS’s rationale for this second BNA is to ensure that site-neutral HCO payments do not

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3 The agency’s only reference to the 2.3 percent figure is found on page 24649 of the proposed rule, and it is very brief. However, page 24540 of the proposed rule references a 5.1 percent estimate instead. Specifically, it states: “For site neutral payment rate cases, we are proposing to use the fixed-loss amount determined annually under the IPPS HCO policy, and we estimate that this would result in an estimated proportion of HCO payments to total LTCH PPS payments for site neutral payment rate cases of 5.1 percent.”
increase aggregate LTCH PPS payments. However, we strongly disagree that the additional 2.3 percent BNA is necessary to achieve this goal; rather, it was already achieved when the 5.1 percent BNA was applied to the inpatient PPS rates used as the basis for the site-neutral rates. We recommend that CMS calculate standard LTCH PPS and site-neutral rates separately, without any co-mingling of these payments. Furthermore, the second BNA prevents LTCH site-neutral payments from aligning with inpatient PPS payments for associated MS-DRG and MS-LTC-DRGs, which would counter the goals of BiBA.

**Regulatory Relief for Site-Neutral Cases**
The KHA opposes CMS’s proposal to apply burdensome regulations that were originally designed for traditional LTCH cases to the new category of site-neutral cases.

**Blended Payments for Site-neutral Cases**
For cost reporting periods beginning in FYs 2016 and 2017, site-neutral cases would be paid a 50-50 blend of the standard LTCH PPS rate and the applicable site-neutral rate. All applicable adjustments would apply to both of the rates contributing to the blended payment. Following this transition period, site-neutral cases would be paid fully site-neutral rates.

**Interrupted Stay and 25% Rule Policies**
CMS proposes applying both the LTCH interrupted stay and 25% Rule policies to site-neutral cases. Under the interrupted stay policy, an LTCH patient experiences a planned, temporary discharge to another setting – most commonly to a general acute-care hospital for a surgery. While 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. As further justification, CMS notes that the interrupted stay policy has prevented “significant and inappropriate expenditures” from the Medicare Trust Fund.

The agency’s proposal to apply both the LTCH interrupted stay and 25% Rule policies to site-neutral cases would fail to treat this new type of LTCH service in a manner that matches Congress’ site-neutral mandate. Both of these regulations were designed for the LTCH case-mix that, on average, has a 25+-day average length of stay and is paid a full LTCH PPS rate. We urge CMS to waive the interrupted stay and 25% Rule policies for site-neutral cases.

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

LTCHs that bill Medicare soon after a patient is discharged also may face timing challenges if the referring inpatient PPS hospital does not also bill Medicare quickly. Some inpatient PPS hospitals exercise the full 180-day billing window allowed under Medicare timely filing guidelines. In such cases, the LTCH’s payment would presumably be placed on hold until the referral hospital’s claim is submitted, since LTCH payment is determined, in part, by the occurrence of an immediate discharge from the prior inpatient PPS hospital, ICU/CCU days in the prior hospital, and, as currently proposed, the discharge status code. This uncertainty, the substantial length of time that may be required to confirm these data and the magnitude of the payment differential, will place LTCHs in a highly precarious situation. KHA urges CMS to give careful consideration to policy remedies that will 1) enable LTCHs to access key data from the referral hospital in a timely fashion; and 2) facilitate timely payment of LTCHs.
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 two percentage point reduction to the LTCH’s annual market-basket update.

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

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

**General Considerations for Implementing The IMPACT Act**

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

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

1. Communicate estimated implementation timelines for all data collection and reporting requirements as early as possible.
2. Use reliable, accurate, feasible and care-setting appropriate measures that are both endorsed by the NQF, and reviewed by the multi-stakeholder Measure Applications Partnership (MAP). We are concerned that two of the proposed measures for FY 2018 lack NQF endorsement.
3. Foster as much standardization of measures and data collection across post-acute care settings as possible, while recognizing that limited variations may still be necessary. CMS may need to alter measures so they work with the data collection mechanisms of a particular care setting, or so that they focus on collecting the data most relevant to a particular patient population. In such instances, CMS could instead focus on achieving “topical” standardization in which all four post-acute care provider types report on the same measure topics, but using data collection instruments and definitions (e.g., rating scales) that may vary.
4. Minimize the burden of collection and reporting requirements. CMS should ensure any new requirements add value and are not unnecessarily duplicative with existing reporting requirements.

**FY 2018 Measurement Proposals**

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

**IMPACT Act Measures**

*Pressure Ulcers*
The KHA supports CMS’s proposal to use the previously finalized pressure ulcer measure to meet IMPACT Act requirements. The measure is NQF-endorsed, and has been collected in the LTCH QRP since the program’s inception.

**Major Falls**
While the KHA appreciates that CMS intends to adopt the falls measure already in use in the LTCH QRP to meet IMPACT Act requirements, we continue to urge the agency to seek and obtain NQF endorsement of the measure for use in LTCHs. The measure assesses the percentage of patients that experience one or more falls with major injury. While the measure is NQF-endorsed, the measure specifications and testing data used to obtain NQF endorsement are specific to nursing homes. As a result, it is not specifically endorsed for use in LTCHs.

We also urge CMS to incorporate risk adjustment into the measure. A patient’s propensity for falls is determined by not only the quality of care, but also a variety of other clinical factors beyond the control of providers, including co-morbid conditions (Kentucky scores poorly on the majority of indicators associated with chronic disease including arthritis, cardiovascular disease and diabetes), baseline level of functioning and so forth.

Furthermore, the IMPACT Act requires that measures include risk adjustment where necessary and appropriate. In the context of quality measurement, risk adjustment is a widely accepted approach to account for some of the factors outside the control of providers when one is seeking to isolate and compare the quality of care provided by various entities. Risk adjustment is meant to create a “level playing field” that allows fairer comparisons of whether providers are doing all they can to ensure the quality of care.

**Functional Status**
To address the IMPACT Act domain of “functional status, cognitive function and changes in function and cognitive function,” CMS proposes to use 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 would collect the measure using a version of the LTCH CARE Data Set modified to collect the needed measure data. At the times of admission and discharge, trained clinicians would be required to numerically score the level of independence that patients demonstrate on several assessment items, including self-care, mobility, cognition, communication and bladder continence. The LTCH CARE Data Set items would include a six-level rating scale. Additionally, LTCH clinicians would be required to record a numerical functional goal score at admission for at least one of the assessment items. LTCHs would be measured on the proportion of their patients with complete assessment data, and not on the actual changes in functional status scores between admission and discharge. KHA is concerned this measure lacks NQF endorsement, is burdensome to collect and has reliability problems based on whether two people collecting the same measure obtain the same measure results. This test of reliability is especially appropriate for the functional status measures because it relies on data collection by multiple clinicians.

In addition, the collection and reporting of these measures would require substantial resources. In order for such an investment of resources to return value to providers seeking to benchmark their quality improvement efforts, and to consumers seeking to understand the quality of care in LTCHs, it is essential that the measure yield accurate results. The available evidence suggests these measures, as currently constructed, fall well short of that standard.
Readmissions Measure

CMS adopted a readmission measure for the FY 2017 LTCH QRP program in the FY 2014 LTCH PPS final rule. For FY 2018, CMS proposes to re-adopt the version of the measure endorsed by the NQF in December 2014. The measure assesses the rate of readmissions to short-term acute care hospitals and LTCHs within 30 days of discharge from an LTCH. The measure is calculated using Medicare fee-for-service claims data, and captures returns of Medicare patients within 30 days of LTCH discharge from the community or another care setting of lesser intensity (e.g., SNFs, home health, IRFs) to an acute care hospital or LTCH. It excludes transfers from an LTCH to either another LTCH or to an acute care hospital. The measure also excludes certain procedures and diagnoses where readmissions are generally considered “planned” events (e.g., chemotherapy, labor/delivery, transplantation, amputations, removal of feeding and tracheostomy tubes, and some colorectal procedures).

Unfortunately, the measure fails to recognize the substantial research showing that community factors outside the control of the hospital – such as the availability of primary care, mental health services, easy access to medications and appropriate food – significantly influence the likelihood of a patient’s health improving after discharge from an LTCH or whether a readmission may be necessary. These community issues are reflected in readily available proxy data on sociodemographic status, such as census-derived data on income (ranked seventh nationally, Kentucky has a higher rate of poverty than all of its surrounding states) and education level, and claims-derived data on the proportion of patients dually eligible for Medicare and Medicaid.

KHA is 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 KHA urges 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

KHA supports CMS’ proposed change to the data submission timeframe for LTCH QRP measures for FY 2017 and beyond which will better “align data submission and correction deadlines” with other quality reporting programs to facilitate public reporting. Most notably, the agency proposes that 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 proposal would take effect with data submitted for the fourth quarter of CY 2015 to meet FY 2017 LTCH QRP reporting requirements, and continue into FY 2018 and beyond.

LTCH QRP Public Reporting

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

1. CAUTI
2. CLABSI
3. Pressure ulcers
4. Readmissions

The initial CAUTI, CLABSI and pressure ulcer measure data would reflect LTCH performance for CY 2015. The readmission measure would measure performance for CY 2013 and CY 2014. CMS does not indicate how often the publicly reported data would be updated.
Similar to other CMS quality reporting programs, the agency proposes to give LTCHs a 30-day period to preview their performance. However, this 30-day period would not provide an opportunity to submit corrections to the data. Instead, CMS states that its proposal to extend the data submission period for LTCH data will give LTCHs sufficient opportunity to review and submit corrections to their data. 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.

However, with nearly all of its other quality reporting programs, CMS allows providers to submit data corrections in conjunction with the data preview period. This is appropriate because the process of collecting and reporting quality measure data is time and resource intensive. It also allows providers and CMS to catch and address any inadvertent data processing errors between the time data are transmitted to the agency and when the data are reported publicly. **KHA urges CMS to permit LTCHs to submit corrections to data during the 30-day preview period.**

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

In particular, we request that CMS:

- **Add encrypted beneficiary ID and admission and discharge dates to both the national and LTCH MedPAR data sets.** These data are necessary to ascertain which cases were immediately discharged from an inpatient PPS hospital.

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

We appreciate the opportunity to express our comments and concerns with the Proposed Rule. We look forward to working with CMS on improving the LTCH PPS FY 2016 and related policies in the Proposed Rule in accordance with these comments. If you have any questions about our comments, feel free to contact me at (502) 426-6220 or pkirchem@kyha.com

Sincerely,

Pam Kirchem  
Director, Membership Services