June 13, 2017

Ms. 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-1677-P Medicare Program; Hospital Inpatient Prospective Payment Systems (PPS) for Acute Care Hospitals and the Long-Term Care Hospital PPS and Proposed Policy Changes and FY 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices; Proposed Rule (Vol. 82, No 81), April 28, 2017

Dear Ms. Verma:

On behalf of our more than 400 member hospitals and health systems, including our six long term care hospital members, the New Jersey Hospital Association (NJHA) appreciates the opportunity to comment on the LTCH provisions in the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2018 proposed rule for the inpatient and LTCH prospective payment systems (PPS). This letter addresses only the LTCH payment and quality-reporting provisions in the proposed rule. We have submitted separate comments on the agency's proposed changes to the inpatient PPS (IPPS) as well as its request for information related to regulatory burden.

NJHA supports a number of the proposed rule's LTCH provisions. **In particular, we appreciate the proposal to extend the current pause on full implementation of the 25 percent rule for an additional 12 months, beginning October 2017. In addition, as discussed below, we urge CMS to use its authority to permanently rescind the 25 percent Rule.** However, we have concerns about other provisions in the rule. Specifically, we remain concerned about the agency's continued application of a duplicative budget neutrality adjustment to the base payment for site-neutral cases, which is producing a systemic and erroneous underpayment of this

category of cases. With regard to the proposed new approach for calculating LTCH short-stay outlier cases, while we support the new methodology, we urge CMS not to apply the associated short-stay outlier budget neutrality factor.

In addition, NJHA recommends that CMS reconsider the adoption of the newly proposed and revised measures for the FY 2020 LTCH Quality Reporting Program (QRP). The measures should undergo additional testing and investigation so that the specifications reflect actual differences in the quality of care provided. **NJHA also believes that the implementation of the standardized patient assessment data elements is too much, too soon, and urges CMS to delay the reporting of the data by at least one year.** The data elements proposed do not have sufficient evidence demonstrating their validity and reliability, and LTCHs would be required to begin collecting the data in less than a year. The burden on providers and difficulty in reconfiguring internal databases, not to mention the significant repercussions on payment associated with the QRP, are too onerous to mandate in such a short time frame.

LTCH 25 PERCENT RULE RELIEF

NJHA applauds CMS's proposal to implement a 12-month regulatory pause on full implementation of the 25 percent rule beginning Oct. 1, 2017. The agency's proposal would seamlessly continue beyond Sept. 30 the 25 percent rule relief authorized by the 21st Century Cures Act-authorized relief, which runs through Sept. 30. However, our overriding concerns about the 25 percent rule remain, as enumerated below, and are the basis for our continued call for CMS to permanently withdraw the policy. **Specifically, we are firmly opposed to the 25 percent rule because it would materially reduce payments for care provided to patients who meet the statutory criteria for a full LTCH PPS rate. Further, given the scale of LTCH cuts under site-neutral payment, implementing the 25 percent rule payment penalties would unjustifiably exacerbate the instability and strain on the field, which would threaten access for the high-acuity, long-stay patients that require LTCH-level care.**

We urge CMS to permanently withdraw the 25 percent rule for the following reasons:

- The 25 percent rule is obsolete. Today's policy landscape for LTCHs is significantly different from that of 2003, when CMS first proposed the 25 percent rule. As a result of the following major changes, the 25 percent rule is misaligned with the current policy framework for LTCHs:
    - The absence of LTCH PPS payment criteria was regularly cited by CMS as a key rationale for implementing the 25 percent rule. However, the Bipartisan Budget Act of 2013 (BiBA) has since required implementation of clinical criteria defining which patients qualify for the LTCH PPS standard rate. As such, this rationale is no longer valid.
    - The scale of the site-neutral cuts is materially reducing aggregate payments to LTCHs – an occurrence unforeseen when the 25 percent rule was first implemented. Specifically, even during the phase-in years when the blended rate

is still in effect, the policy produced major payment reductions to the site-neutral category: - 23.0 percent for FY 2017 and -14.8 percent for FY 2016. In addition, a further reduction of 22 percent is estimated for FY 2018. Given the magnitude of these cuts and the scope of the policy (*CMS estimates that 42 percent of all LTCH cases in FY 2018 will fall in the site-neutral category*), the field must re-tool operations, with some LTCHs focusing solely on LTCH PPS cases and others re-configuring their operations to create distinct clinical programs for the traditional LTCH and site-neutral patient populations. As noted above, if the 25 percent rule payment penalties are implemented at the same time as these substantial cuts and major transformation in the field, it would unjustifiably exacerbate LTCH instability, which would threaten access for the high-acuity, long-stay patients that require LTCH-level care,

- Alternative payment models, such as bundled payment, also are reducing LTCH utilization due to the setting's high cost. This additional reduction in overall Medicare spending on LTCHs, which also was unanticipated when CMS initially designed the 25 percent rule, further heightens our concern about instability in the field.

- The 25 percent rule counters the statutory requirements on LTCH PPS payment. In BiBA, Congress mandated which cases are to be paid an LTCH PPS standard rate, rather than the far lower site-neutral rate. These criteria distinguish patients according to their medical acuity, as indicated by intensive care unit (ICU) and coronary care unit (CCU) use in the prior hospital stay and other metrics. Yet, the 25 percent rule would reduce this mandated payment for some cases that qualify for a standard rate due to the origin of their referral, directly contradicting the payment requirements in BiBA.

- The new criteria for LTCH PPS standard rate cases address CMS's concerns regarding LTCH medical necessity. The BiBA criteria also directly address another CMS rationale for the 25 percent rule that LTCHs provide medically unnecessary care when functioning as "step-down units" for hosting or nearby general acute-care hospitals. However, by identifying the cases that qualify for an LTCH PPS standard rate, the BiBA criteria serve as de facto medical necessity criteria, effectively eliminating the agency's concern regarding LTCHs serving as step-down units.

- The 25 percent rule is arbitrary. The 25 percent rule is non-clinical in nature, targeting patients based on their referral source rather than clinical needs. This is a flawed and arbitrary manner in which to create a policy. As a result, it presents an access barrier for patients who are clinically appropriate for the LTCH setting. In fact, the Medicare Payment Advisory Commission (MedPAC) March 2011 report to Congress described this aspect of the policy as "blunt" and "flawed."

- CMS has the authority to rescind the 25 percent rule. The 25 percent rule was established through regulation in the FY 2004 LTCH PPS final rule. While multiple congressional bills have temporarily blocked full implementation of the 25 percent rule,

the resulting statutory language did not mandate implementation of the policy. Thus, CMS has the authority to rescind the policy.

SITE-NEUTRAL CASES ARE BEING UNDERPAID DUE TO DUPLICATIVE BUDGET-NEUTRAL ADJUSTMENTS

NJHA appreciates CMS's decision in the FY 2017 final rule to remove the second budget neutral adjustment (BNA) it had been applying to the high-cost outlier (HCO) portion of site-neutral payments. However, we remain very concerned that the agency continues to apply the duplicative BNA to the non-HCO portion of site-neutral payments. In its FY 2016 through FY 2018 rulemaking, CMS stated that its rationale for applying a 5.1 percent reduction (hereafter "5.1 percent BNA") to the site-neutral portion of the blended payment was to avoid any "increase in aggregate LTCH PPS payments." **However, CMS' decision to apply two BNAs is yielding a material, unwarranted payment reduction to LTCH site-neutral cases. We strongly urge the agency to withdraw the duplicative BNA.** These site-neutral cases are inappropriately subject to two BNAs:

- The first 5.1 percent BNA is applied when CMS sets the IPPS rates used to calculate the IPPS comparable per diem amount paid to site-neutral cases;
- The second BNA occurs within the LTCH PPS framework, when a second 5.1 percent BNA is applied to the non-HCO portion of the site-neutral payment.

Duplicative BNA does not promote fairness between IPPS and the LTCH PPS. In the FY 2018 IPPS/LTCH proposed rule and other prior rules, CMS states that it believes that using the same fixed-loss amount for site-neutral cases as it does for IPPS cases "will reduce differences between HCO payments for similar cases under the IPPS and site-neutral payment rate cases under the LTCH PPS and promote fairness between the two systems." Yet CMS continues to apply the second, duplicative BNA to the non-HCO portion of the site-neutral payment – this not only causes disparities in the HCO and non-HCO portions of payments between IPPS and the LTCH PPS, but reduces fairness between the two systems. This disparity was also expressed by MedPAC, as noted below.

MedPAC also views the second BNA as duplicative. In its May 31, 2016 comment letter on the FY 2017 IPPS/LTCH PPS proposed rule, the commission 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."

Duplicative BNA has a substantial negative impact. Using the FY 2015 MedPAR data, AHA has estimated that the second BNA within the LTCH framework reduces site-neutral payments by approximately $30-$50 million per year, a substantial amount. This estimate assumes full implementation of site-neutral payment and costs that are similar to IPPS levels versus historical LTCH costs.

SHORT-STAY OUTLIER POLICY PROPOSALS

NJHA supports CMS' proposal to change the existing short-stay outlier (SSO) policy by replacing the various payment options with a single graduated per diem adjustment. However, we urge CMS not to apply its related proposed one-time permanent budget neutrality factor to the LTCH PPS standard Federal payment rate in FY 2018. Given the tremendous instability in play with the shift to a dual-rate payment structure, application of a duplicative BNA to the site-neutral payment, and the significant increase in the proposed FY 2018 HCO fixed-loss threshold amount for LTCH standard rate cases, the LTCH field is confronting enormous financial pressure. Furthermore, it is impossible to predict the direction of the field as it struggles to adapt to the dual-rate payment structure, making the actuaries' assumption that there will be a behavioral response of a 10 percent increase in SSO cases arbitrary and inconsistent with the data that CMS examined. The field simply cannot tolerate another large reduction to payments and we urge CMS to do everything in its power to mitigate the instability already being caused.

MAINTAINING ACCESS AND PAYMENTS FOR HIGH-RESOURCE SITE-NEUTRAL CASES

As Medicare approaches the end of the transition from the single-rate LTCH PPS to the dual-rate version of the payment system, we ask CMS to examine access to care for those site-neutral cases that require specialized high-resource LTCH services. These cases, which include certain severe wound cases, appear to have a cost and average length of stay (ALOS) profile that does not match those of corresponding inpatient PPS MS-DRGs, and thus also appear to be underpaid. As such, while CMS speculated that the resource needs for LTCH site-neutral and inpatient PPS cases would align, it instead appears that some types of site-neutral cases continue to look more like traditional LTCH cases. We believe that site-neutral cases that remain relatively costlier and have longer ALOSs than their inpatient PPS counterparts should be examined to determine if they are being underpaid. We also ask the agency to examine how site-neutral acuity levels and other indicators of resource needs contrast with cases in the comparable inpatient PPS MS-DRGs.

Indeed, Congress has recognized that certain severe wound cases in qualifying LTCHs warrant a waiver from site-neutral payment, and authorized their payment at an LTCH standard rate level on a short-term basis. However, such legislative relief, provided by the Consolidated Appropriations Act of 2016 and 21st Century Cures Act, provided a temporary reprieve for a relatively small number of cases. Given the limited nature of this relief, and our growing awareness that certain site-neutral cases may require resources that exceed inpatient-PPS levels, we encourage CMS to undertake a close examination of these cases and consider whether new policy and payment interventions are needed to ensure that these cases have access to high-quality care.

LTCH QRP

All-cause Unplanned Readmission Measure for 30 Days Post-Discharge from LTCHs. **NJHA is pleased with CMS' proposal to remove this duplicative and confusing measure from the LTCH QRP and supports its removal.** We continue to urge CMS to review the remaining readmission measures used across its PAC quality programs to ensure that they create consistent improvement incentives across the system.

STANDARDIZED PATIENT ASSESSMENT DATA REPORTING

In addition to requiring standardization and alignment of quality measures, the IMPACT Act also requires the collection of standardized patient assessment data. The reporting of these data is a requirement of the PAC quality reporting programs; as a result, failure to comply with the requirements would result in a 2.0 percentage payment reduction. In an attempt to facilitate data sharing and comparisons across PAC settings, CMS proposes to introduce the required reporting of standardized data elements into each setting's respective assessment tools; for the LTCH setting, this would entail the addition of several new data elements to the CARE Data Set. Specifically, the agency would require LTCHs to collect data on functional status, cognitive function, medical conditions, impairments, and several types of special treatments and services. While PAC providers would fulfill the FY 2019 requirement by reporting data elements already implemented in the various quality reporting programs (namely, those used to calculate the Percent of Residents or Patients with Pressure Ulcers that are New or Worsened, Short Stay), LTCHs would be required to report data based on several new elements starting on April 1, 2018.

NJHA believes the implementation of these data elements is too much, too soon. We urge CMS to delay the reporting of the data elements by at least one year (i.e., to allow the reporting of elements associated with the Pressure Ulcer measure to fulfill the FY 2019 and 2020 requirements), and to carefully assess whether all of them are necessary to meet the IMPACT Act mandate.

Validity and Reliability of Elements. Of the proposed 23 data elements, only five are currently reported in the CARE Data Set. The other 18 are used in other post-acute setting tools, mainly the Minimum Data Set (MDS) 3.0 used in skilled nursing facilities (SNFs). CMS purports that the use of these elements in the MDS and the testing in the Post-Acute Care Payment Reform Demonstration (PAC PRD) are sufficient to show that collection of these elements in the LTCH setting is feasible and that the elements will result in valid and reliable data. Unfortunately, the PAC PRD results were significantly impacted by small sample sizes, and the reliability of many data elements was poor. Thus, it is unwise to rely on results from that project to judge the integrity of the proposed LTCH CARE data elements. In addition, for several of the elements, the precise items CMS proposes to add have not been tested in the PAC PRD or another PAC setting; rather a similar or related item was deemed close enough and thus appropriate for implementation.

Considering that providers are asked to report on these 23 data elements for admissions and discharges beginning in less than a year, and that failure to report would result in a significant decrease in their market basket update, **we believe that CMS has not provided sufficient evidence that these data elements are ready for inclusion in the LTCH QRP.**

Burden on Providers. As mentioned previously, CMS's proposal would add 18 new data elements to the already lengthy CARE Data Set. **Because many of these elements have multiple parts (i.e., a principal element and 2-7 sub-elements or questions), this could result in more than 50 additional tasks for a provider to complete.** While any one task may not take a long time to complete, the addition of all of these elements at once would change a LTCH provider's workflow considerably.

In fact, CMS is currently engaged in multiple contracts to develop several additional standardized patient assessment data elements for future years in PAC QRPs. Unless CMS is planning to significantly reduce the current reporting burdens on PAC providers, it is unrealistic to mandate that providers comply with an exponentially growing list of reporting requirements. We also are concerned about LTCH providers' ability to reconfigure their databases and EHRs by April 2018 to comply with these reporting requirements. For these reasons, we strongly urge CMS to delay implementation of these new data elements. Because the IMPACT Act requires the collection of standardized patient assessment data for fiscal year 2019 and each subsequent year, CMS could consider data already reported in a standardized manner across the various PAC settings to be sufficient for FY 2019 and FY 2020. **CMS proposes that reporting of the elements used to calculate the Pressure Ulcer measure, which has been implemented in all four PAC settings, would satisfy the statutory requirement; NJHA suggests continuing this approach for an additional year to allow for further consideration of the additional data elements.**

FUTURE CONSIDERATIONS FOR THE LTCH QRP

In addition to proposing expansions and modifications to the LTCH QRP for proximal program years, CMS also invited public comment on the importance, relevance, appropriateness and applicability of quality measures for future years in the LTCH QRP. We appreciate the opportunity to provide input on these longer term proposals, and hope that CMS incorporates our and others' comments thoughtfully as the agency further develops the LTCH QRP.

Development of Experience of Care Survey-based Measures. **NJHA favors the use of patient experience surveys as tools to help providers improve the engagement and satisfaction of patients and their families. However, the proliferation of questions on such surveys has resulted not only in substantial costs to providers to collect the data, but also a significant burden to patients.** Indeed, many patients have expressed frustration about the length of surveys and the amount of time it takes to complete them. It is critical that surveys include an essential set of questions so that valuable patient time and finite provider resources are used efficiently and effectively.

We urge that any patient experience of care survey for LTCHs be carefully aligned with other surveys to reduce duplicative collection activities. A patient's course of care often crosses multiple care settings and providers within a given time period, and the Consumer Assessment of Providers and Systems (CAHPS) program has surveys for nearly every setting. Indeed, CAHPS includes surveys for physicians, hospitals, nursing homes, dialysis facilities and home health agencies. Patients who receive care in two or more of these settings could receive multiple surveys. Typically, surveys are not distributed until days or weeks after a patient has received their care. This may create confusion about which provider or facility is actually being assessed. A patient may inadvertently attribute a positive or negative experience to the wrong provider.

NJHA also strongly recommends that CMS explore the development of more economical survey administration approaches for patient experience surveys, such as emailed or web-based surveys. While we appreciate the value of assessing the patient experience across the care continuum, the use of multiple surveys means more time spent by patients to answer surveys and more resources expended by providers to administer them. Moreover, for the purposes of CMS reporting programs using CAHPS tools, providers are permitted to use only two survey administration modes – mailed surveys and telephone surveys. Mailed surveys are relatively inexpensive to administer, but often suffer from low response rates and significant time lag. Telephonic surveys typically yield a higher response rate and provide more timely results, but are much more expensive to administer.

Modification of Discharge to Community Measure. **NJHA supports the modification to this measure, which would exclude baseline nursing facility residents from the calculation.** As CMS notes, these residents did not live in the community prior to their LTCH stay and thus would not necessarily be expected to return "successfully" to the community following discharge as specified in the measure. This modification would more accurately portray the quality of care provided by LTCHs while controlling for factors outside of the LTCH's control.

IMPACT Act Measures on Transfer of Information. **NJHA urges CMS to be cautious in its development of these Transfer of Information measures, and only adopt the measures once they have been endorsed by the National Quality Forum (NQF).** The measures under development include "Transfer of Information at Post-Acute Care Admission, Star or Resumption of Care from Other Providers/Settings" and "Transfer of Information at Post-Acute Care Discharge to Other Providers/Settings and End of Care." We agree that the transfer of information between and among post-acute care settings is vital to ensuring safe and high-quality patient care; however, these measures are still in the early stages of development.

As noted in the proposed rule, CMS intends to specify these measures no later than October 1, 2018 and begin data collection on or about April 1, 2019. If these measures cannot pass the NQF endorsement process prior to those dates, **we urge CMS to delay implementation of these measures until they receive endorsement.**

We thank you for the opportunity to comment on this proposed rule. Please contact me if you have questions. I can be reached at tedelstein@njha.com or at 609-275-4102.

Sincerely,

Theresa Edelstein, MPH, LNHA
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