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

The Issue:
On April 30, the Centers for Medicare & Medicaid Services (CMS) published its fiscal year (FY) 2016 proposed rule for the inpatient and long-term care hospital (LTCH) prospective payment systems (PPS). This advisory covers the rule’s LTCH-related provisions. An AHA Regulatory Advisory on the inpatient PPS provisions was sent to members separately. In addition to proposing the annual payment update for the LTCH PPS rates, this rule proposes implementation of the Bipartisan Budget Act’s (BiBA) requirement to implement site-neutral payments for certain LTCH cases that, in general, have lower medical acuity beginning on Oct. 1, 2015. Specifically, under BiBA’s new dual-rate system, certain qualifying cases will be paid the traditional LTCH PPS rate, while others will be paid a lower site-neutral rate that will be based on an inpatient PPS rate. For cost reporting periods beginning in FYs 2016 and 2017, site-neutral cases would be paid a 50-50 blend of the standard LTCH PPS rate and the applicable site-neutral rate. Following this transition period, site-neutral cases would be paid fully site-neutral rates.

CMS estimates that for FY 2016, when combining the impact of the LTCH PPS payment update (1.2 percent increase) with the impact of adding the site-neutral payment component (14.3 percent decrease), LTCHs would face a net decrease of 4.6 percent. This change would reduce total Medicare payments to $5.169 billion in FY 2016, a reduction of $251 million from FY 2015 levels.

The rule also proposes substantial changes to the LTCH Quality Reporting Program (LTCH QRP).

Our Take:
The addition of a site-neutral payment component to the LTCH PPS is a major transformation for the LTCH field. While the magnitude of this change is significant, CMS’s proposals for implementation appear to be in line with Congress’ intent in BiBA. The AHA is conducting in-depth analysis of all aspects of the site-neutral proposals. In addition, to help LTCHs prepare for this major change, we are preparing LTCH-specific impact reports to estimate the portion of each LTCH’s current case mix that would be subject to site-neutral payment, as well as other information.

What You Can Do:
✓ Share the attached summary with your senior management team to examine the affect these payment changes would have on your organization for FY 2016.
✓ Participate in an AHA member call on Friday, May 15 at 2:00 p.m. ET to provide feedback to AHA staff on your concerns with this regulation. Click here to register in advance.
✓ Look for your LTCH-specific impact estimate from AHA, which will follow in the weeks ahead.
✓ Submit written comments to CMS on your feedback and concerns with this rule by June 16.

Further Questions:
Please contact Rochelle Archuleta, director of policy, at (202) 626-2320 or rarchuleta@aha.org.
BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) published its fiscal year (FY) 2016 proposed rule for the hospital inpatient and long-term care hospital (LTCH) prospective payment systems (PPS) in the April 30 Federal Register. This advisory covers the rule’s LTCH-related proposals. Please refer to the April 29 Regulatory Advisory for analysis of the inpatient PPS provisions. An online addendum contains tables with LTCH data that accompany this rule.

In addition to other changes, this 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 Oct. 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. Upon AHA’s initial review, CMS’s proposals to implement this provision appear to align with the intent of Congress.

CMS estimates that for FY 2016, when combining the impact of the LTCH PPS payment update (1.2 percent increase) with the impact of adding the site-neutral payment component (14.3 percent decrease), LTCHs would face a net decrease of 4.6 percent. This change would reduce total Medicare payments to $5.169 billion in FY 2016, a reduction of $251 million from FY 2015 levels.

FY 2016 PROPOSED PAYMENT UPDATE AND PROPOSED NEW CRITERIA FOR STANDARD LTCH 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. This section of the advisory reviews CMS’s proposed methodology for updating the standard LTCH PPS rates and adding new BiBA-required criteria to qualify for these rates.
**FY 2016 Standard LTCH PPS Rate**

For FY 2016, CMS proposes to apply a market-basket update of 2.7 percent, which is based on the LTCH-specific market basket implemented in FY 2013. The market basket will be reduced by two cuts mandated by the Affordable Care Act: a 0.6 percentage point reduction for productivity and an additional 0.2 percentage point reduction. As a result, the proposed standard rate for FY 2016 is $41,883.93, compared to $40,607.31 for FY 2015. LTCHs not reporting required quality data would be subject to a 2.0 percentage point reduction in the market-basket update, for a standard rate of $41,061.87.

**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.

The rule proposes more detailed definitions of these criteria to qualify for a standard LTCH PPS rate:

- **Psychiatric and Rehabilitation Cases.** CMS proposes that cases with the following 15 Medicare-severity-LTC-diagnosis-related groups (MS-LTC-DRGs) for psychiatric and rehabilitation conditions would not be paid a standard LTCH PPS rate, but would instead be paid a site-neutral rate:

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

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.

• **ICU/CCU Revenue Codes.** As urged by the AHA, CMS proposes to use the full set of 18 ICU (020x) and CCU (021x) revenue codes when counting a patient’s ICU and CCU days during the prior general acute-care hospital stay. AHA analysis of general acute-care hospital coding practices found that hospitals use a wide array of coding approaches, as allowed under the Medicare guidelines. As a result of this variation, we had recommended that all 18 codes be counted when assessing eligibility for a standard LTCH PPS rate.

• **Ventilator Criterion.** CMS proposes that ICD-10 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.

**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 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. We note 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.

**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**
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.

**Adjustment for High-cost Outliers**
Under the new dual-rate payment system for LTCHs, CMS proposes separate high-cost outlier policies for standard LTCH PPS cases and site-neutral cases. In FY 2016, for cases paid the standard LTCH PPS rate, CMS proposes to maintain an 8-percent outlier pool. The fixed-loss amount for this pool would be calculated using only the FY 2014 MedPAR cases that would have been paid the standard LTCH PPS rate. CMS proposes no other modifications to its LTCH high-cost outlier methodology. Its proposals yield a FY 2016 fixed-loss amount of $18,768, which is higher than the FY 2015 fixed-loss amount of $14,972. Details on the proposed outlier threshold for the site-neutral payment tier are below.

**PROPOSED IMPLEMENTATION OF LTCH SITE-NEUTRAL PAYMENT**

As noted, this rule proposes to implement the BiBA requirement to add a site-neutral component to the LTCH PPS beginning with cost-reporting periods starting Oct. 1, 2015 and later. In the LTCH impact file that accompanies this rule, CMS has estimated the number of site-neutral cases per LTCH, and in the MedPAR data CMS identified each LTCH’s FY 2014 cases that would meet the site-neutral payment criteria. However, CMS has not made available the key data points needed to replicate and validate these site-neutral payment designations; for now the AHA must rely on the agency’s identification of site-neutral cases. However, we note that the estimate of total cases in FY 2014 that would be paid a site-neutral rate, 46 percent, is very close to AHA’s prior estimate of 47 percent. AHA is currently updating all of our analyses on LTCH site-neutral payment, including LTCH-specific impact estimates.

**Calculation of the LTCH Site-neutral Rate**
CMS proposes a site-neutral payment rate that is based on the lower of the inpatient PPS-comparable per-diem amount, including any outlier payments, or 100 percent of the estimated cost of the case. The sections below describe how CMS proposes to calculate these amounts, including statutorily-required outlier payments. Site-neutral
payment would be phased in for cost reporting periods beginning Oct. 1, 2015 through Sept. 30, 2017, as described below, and would be in full effect thereafter.

**Proposed Calculation of the Inpatient PPS-comparable Per-diem Amount.** CMS proposes to base the inpatient PPS-comparable per-diem amount on the standardized amount for the corresponding inpatient PPS MS-DRG. This amount would be adjusted for an LTCH's area wage index, disproportionate share of low-income patients, inpatient capital-related costs, and indirect medical education for “teaching LTCHs.” The resulting inpatient PPS-comparable amount would be divided by the inpatient PPS geometric mean average length of stay for the associated MS-DRG, and then multiplied by the covered days on an LTCH claim. Then any applicable high-cost outlier payments would be added. The resulting amount would be capped at 100 percent of estimated cost. Stated another way, CMS proposes to calculate this payment by multiplying the inpatient PPS-based per-diem amount by the number of covered LTCH days, adding in any applicable outlier payments, and capping the total payment at 100 percent of the LTCH’s estimated cost.

For site-neutral cases that are paid the per-diem amount, CMS proposes a high-cost outlier payment that is equal to 80 percent of the difference between the estimated cost of the case and the high-cost outlier threshold, which CMS proposes would be the sum of the site-neutral payment rate and the inpatient PPS fixed-loss amount. The agency proposes to apply the inpatient PPS fixed-loss amount to site-neutral cases that are high-cost outliers, which, for FY 2016, are estimated to be $24,485.

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

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

CMS also proposes that when reconciliation for cost report settlement occurs, site-neutral payments would be adjusted to account for the time value of any underpayments or overpayments. Such adjustment would apply from the midpoint of the cost reporting period to the date of reconciliation. The index used to calculate the time value of any such adjusted funds would align with the Medicare Trust Fund’s monthly rate of return.
CMS proposes that site-neutral cases paid 100 percent of cost would not be eligible for outlier payments because, by definition, the cost of the case would not exceed the payment for the case.

Blended Payments for Site-neutral Cases. For cost reporting periods beginning in FYs 2016 and 2017, site-neutral cases 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.

LTCH Discharge Ratio Requirement. As required by BiBA, in FY 2016, CMS proposes to begin reporting the portion of each LTCH’s cases that are site-neutral cases. Beginning with FY 2020 cost-reporting periods, if site-neutral cases exceed 50 percent of total discharges, an LTCH will be fully paid as a general acute-care hospital under the inpatient PPS for the subsequent cost-reporting period. CMS stated that it will be issuing sub-regulatory details on this requirement in the future.

Short-Stay Outlier (SSO) Adjustment. CMS is not proposing to apply the SSO payment adjustment to site-neutral cases, as they – like a majority of SSO cases – are already subject to significant payment reduction to the inpatient PPS level.

Proposed Changes to LTCH Average Length of Stay Calculation

To comply with statutory requirements, CMS proposes to change the calculation of the average length of stay for LTCHs. Today, to be classified as an LTCH, a hospital must maintain an average length of stay of greater than 25 days, which is calculated by dividing the total number of Medicare and non-Medicare inpatient days by the total number of Medicare discharges. Under the rule, this methodology would be modified by removing from the calculation LTCH cases paid a site-neutral rate or by a Medicare Advantage plan. In addition, the revised policy would not apply to any LTCH that was certified under the Medicare program as of Dec. 10, 2013.
LTCH Quality Reporting Program (LTCH QRP)

The Affordable Care Act mandated that reporting of quality measures for LTCHs begin no later than FY 2014. Failure to comply with LTCH Quality Reporting Program (LTCH QRP) requirements will result in a 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. A detailed summary of the IMPACT Act’s requirements can be found in the AHA’s Oct. 16, 2014 Legislative Advisory. 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). Table 1 below summarizes the finalized and proposed measures for the LTCH QRP.

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

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

X = Finalized
X’ = Finalized in previous rules, re-proposed in FY 2016 LTCH PPS Proposed Rule

FY 2018 Measurement Proposals

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

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

**Pressure Ulcers.** To address the IMPACT Act’s “skin integrity” measure domain, CMS proposes to use the LTCH QRP’s existing pressure ulcer measure. The measure assesses the percentage of patients with stage 2 to 4 pressure ulcers that are new or worsened since admission to the LTCH. This measure is NQF-endorsed and has been collected in the LTCH QRP since the program’s inception. CMS proposes to continue collecting measure data using the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set, with data submitted using CMS’s Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. Additional details on this measure can be found on CMS’s LTCH QRP website.

**Major Falls.** To address the IMPACT Act domain of “major falls,” CMS proposes to use the LTCH QRP’s measure assessing the percentage of patients that experience one or more falls with major injury. CMS proposes to continue collecting measure data using the LTCH CARE Data Set, with data submitted using the agency’s QIES ASAP system. While the measure is NQF-endorsed, the measure specifications and testing data used to obtain NQF endorsement are specific to nursing homes. As a result, it is not specifically endorsed for use in LTCHs. Nevertheless, CMS proposes to continue using this measure because it believes it meets the IMPACT Act’s requirement that measures be “interoperable” across care settings. **While the AHA agrees it is reasonable for CMS to select a measure that has already been finalized for the LTCH QRP, we continue to believe the measure should be NQF-endorsed for use in LTCHs before it is adopted for the program.**

**Functional Status.** To address the IMPACT Act domain of “functional status, cognitive function and changes in function and cognitive function”, CMS 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.

The AHA disagreed with CMS’s decision to finalize this measure in last year’s rule. We remain concerned this measure lacks NQF endorsement and is burdensome to collect.

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. This measure assesses the rate of readmissions to general acute care hospitals and LTCHs within 30 days of discharge from an LTCH. The measure is calculated using Medicare fee for service (FFS) claims data, and captures returns of Medicare patients within 30 days of LTCH discharge from the community or another care setting of lesser intensity (e.g., skilled nursing facilities, home health, inpatient rehabilitation) to a general 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).

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

Data Submission Requirements

Data Submission Timelines. CMS proposes several revisions to the data collection and submission timeframes for the LTCH QRP for FY 2017 and beyond that it suggests would "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. The proposed data submission timeframes are outlined in Appendix A of this advisory.

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:
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. The AHA will urge CMS to permit LTCHs to submit corrections to data during the 30-day preview period.

The agency intends to announce the preview period, as well as the specific date when it would begin to publicly display data, using its listservs, website and other communications vehicles. CMS also suggests that once it has “a sufficient number of [LTCH QRP] quality metrics to allow for variation and differentiation among LTCHs, it may adopt a “star rating” system for the LTCH QRP.”

**Other Proposed Rule Provisions**

**ICD-10 Implementation**
ICD-10 is scheduled to take effect for the LTCH PPS on Oct. 1, 2015. In the rule, CMS solicits comments on the MS-DRG (and by extension, the MS-LTC-DRG) logic used for payment that is currently in ICD-9-CM and will be in ICD-10 for FY 2016.

**Moratorium on New LTCHs**
BiBA also required a moratorium on new LTCHs, satellites and beds, which was amended by the Protecting Access to Medicare Act of 2014. This statutory moratorium applies from April 1, 2014 through Sept. 30, 2017, and outlines certain exceptions under which a new LTCH or satellite may be opened. No moratorium exceptions apply for bed expansions.

In this rule, CMS clarifies that to qualify for an exception to the moratorium, new facilities were required to meet one of the three exceptions by April 1, 2014:

- The facility had begun its qualifying period to demonstrate compliance with the 25+ day average length of stay required for classification as an LTCH;
- The facility has a binding written agreement with an outside, unrelated party for the construction, renovation, lease or demolition of the space that will house the
LTCH, and has expended at least 10 percent of the estimated cost of the project, or if less, $2.5 million; or

- The facility has obtained an approved certificate of need in a state where one is required.

In addition, the proposed rule addresses confusion concerning the calculation of “estimated cost of the project” under the second moratorium exception. The statute requires that the “cost of the project” includes “actual construction, renovation, lease, or demolition for a long-term care hospital.” In the rule, CMS restates its policy, which also applied for prior LTCH moratoria, that despite the use of “or” in this exception, CMS requires that the calculation of estimated costs include all costs associated with any of the enumerated activities.

CMS also clarifies that for any organization that opened an LTCH satellite during the moratorium, beds for the new satellite facility must be transitioned from among the organization’s tally of total beds that were in existence on March 30, 2014. The organization’s total bed count, including those in the new satellite, cannot exceed its total bed count as of March 30, 2014.

**NEXT STEPS**

The AHA will host a member conference call on Friday, May 15, at 2:00 p.m. ET to discuss the provisions of the proposed rule and to gather input from the field for our comment letter to CMS. To register for this call, click here. Related materials and a recording of this call will be available at: www.aha.org/postacute in the LTCH section.

**Submitting Comments Electronically.** The AHA urges all LTCHs to submit comments to CMS. Comments are due by June 16 and may be submitted electronically at: www.regulations.gov, referring to “1632-P” to submit comments on this proposed rule.

**Mailing Written Comments.** You also may mail written comments to CMS.

**Via regular mail:**
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1632-P
P.O. Box 8016
Baltimore, MD 21244-8016

**Via overnight or express mail:**
Centers for Medicare & Medicaid Services
Dept. of Health and Human Services
Attention: CMS-1632-P
Mailstop: C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Please contact Rochelle Archuleta, director of policy, at (202) 626-2320 or rarchuleta@aha.org with any feedback or questions on this rule.
## Appendix A

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

**Key:**

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

<table>
<thead>
<tr>
<th>Measure</th>
<th>FY 2017 Data Collection</th>
<th>FY 2017 Deadline</th>
<th>FY 2018 Data Collection</th>
<th>FY 2018 Deadline</th>
<th>Subsequent Fiscal Year Data Collection</th>
<th>Subsequent Fiscal Year Deadlines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of nursing home residents with pressure ulcers that are new or worsened(^Q)</td>
<td>Jan. 1 – Mar. 31, 2015</td>
<td>May 15, 2015</td>
<td>Jan. 1 – Mar. 31, 2016</td>
<td>Aug. 15, 2016(^P)</td>
<td>Q1: Jan. 1 – Mar. 31(^P)</td>
<td>Quarterly, approximately 135 days after the end of each calendar quarter</td>
</tr>
<tr>
<td>Measure</td>
<td>FY 2017 Data Collection</td>
<td>FY 2017 Deadline</td>
<td>FY 2018 Data Collection</td>
<td>FY 2018 Deadline</td>
<td>Subsequent Fiscal Year Data Collection</td>
<td>Subsequent Fiscal Year Deadlines</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>----------------------------------------</td>
<td>------------------------</td>
<td>-----------------------------</td>
<td>------------------------</td>
<td>----------------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Unplanned all-cause, all condition readmissions to LTCHs</td>
<td>Two years of Medicare claims: Jan. 1, 2013 – Dec. 31, 2014</td>
<td>N/A – calculated by CMS</td>
<td>Not proposed</td>
<td>Not proposed</td>
<td>Not proposed</td>
<td>Not Proposed</td>
</tr>
</tbody>
</table>


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

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

<sup>P</sup> indicates the dates are subject to the agency’s final rule.
Conference 2015
Day One – 0800 – 1700 hours

Keynote - Learning from Ebola: Perspectives from a Provider and Patient
Craig Spencer, MD MPH
Assistant Professor of Medicine at Columbia University Medical Center
Attending Physician in Emergency Medicine - New York Presbytarian
Physician, Doctors Without Borders

Dr. Spencer will share his experience treating Ebola patients in West Africa and what he learned from the patients and communities affected by this epidemic.

Emerging Infectious Disease, Ebola Response in Sierra Leone
Raymond Cordi, FNP, EMT-P
Nurse Practitioner, Lincoln Hospital
Paramedic, Empress Ambulance

Mr. Cordi will present his personal experience as a responder to the Western Africa Ebola outbreak in Sierra Leone.

Fantasy Islands of Preparedness, Plot Twists, and Liabilities
Donald A. Donahue. Jr., DHEd, MBA, FACHE
American Academy of Disaster Medicine

Dr. Donohue will provide an examination of planning assumptions, lessons learned, and operational and legal liabilities from disaster related failures.

Crossing Our Wires, The Continued Failure of Communications in Disaster
Heidi Cordi, MD, MPH, MS, EMTP, FACEP
Attending Physician in Emergency Medicine - New York Presbytarian
Founding Secretary, American Academy of Disaster Medicine

Dr. Cordi will discuss the reasons why, for over 20 years, communications failures continue to be one of the greatest causes of response system failure.

The Mental Health Footprint of Disaster
Kaitlyn McLachlan, Ph.D., C. Psych.
Forensic Psychiatry Program
St. Joseph's Healthcare, Hamilton, Ontario

Dr. McLachlan will investigate the impact of disasters on individuals, communities and responders.
Behavioral Health-A New Look
Ed Thornton, DO
American Academy of Disaster Medicine

Dr. Thornton will look at traditional roles and ways of practicing behavioral health in disasters. He will also discuss who needs behavioral health and delivering care from a different point of view. He will outline the many advantages of team, or POD approaches and will explore how to have a greater impact using this approach.

All Hazards Preparedness
Lorraine Giordano, MD, FACEP, ABODM
American Academy of Disaster Medicine
Board Member, NYC Regional EMS Council
Former Chair, NYC Regional Medical Advisory Committee, NYS Medical Advisory Committee
On-Line Medical Control Physician – NYC Fire Department

Dr. Giordano will focus on lessons learned from a train derailment, hazardous materials spill and a fertilizer plant blast to identify a process for evaluation of risk and the enhancement of the current response system.

Twisting your Disaster Plan
Lessons Learned from the 2011 Tuscaloosa, Alabama Tornado
Andrew Lee RN, MSN, CNL, CEN
Interim ED Nurse Manager, Trauma Coordinator, Flight Nurse
DCH Health System, Tuscaloosa, Alabama

Mr. Lee will present the DCH Health System response to the 2011 EF-4 tornado in Tuscaloosa, Alabama and how his facility disaster plan was tested.

Day 2 – 0800 – 1200 hours

On day two, the speakers will participate in an unscripted panel discussion dedicated to identifying the future of disaster planning as well as investigating new initiatives in education, preparedness and response. Audience members will be encouraged to participate with the panel and may be asked to share their experiences and planning processes as part of the program.
Sanford Health
emergency management
Conference 2015
Sanford Center
May 28th and 29th

Highlights
International Ebola Response
Communications Failure
Rural Disasters
Tornado events
Planning and litigation
Emotional impact of disaster
Expert Round Table Discussion on Planning and Response

Speakers
Craig Spencer, MD MPH
Ed Thornton, DO, AADM
Kaitlyn McLachlan, Ph.D., C. Psych
Heidi Cordi, MD, MPH, MS, EMT-P, FACEP
Donald A. Donahue. Jr., DHed, MBA, FACHE
Lorraine Giordano, MD, FACEP, ABODM
Mr. Ray Cordi, NP
Mr. A. Lee, NP

Partners

Funded by a grant from the Regional Coalitions of the South Dakota Department of Health

Registration Information

Register

NOTE: Telehealth may be available in your area. Please check back on the registration link frequently for updated telehealth locations.

For additional Information, please contact Greg Santa Maria at Greg.SantaMaria@sanfordhealth.org