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Advancing Health in America

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June 7, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services,
Attention: CMS-1808-P
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted Electronically

Re: Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes; 89 Fed. Reg. 35,934 (May 2, 2024).

Dear Administrator Brooks-LaSure:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 230 long-term care hospitals (LTCH), and our clinician partners — more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2025 LTCH prospective payment system (PPS) proposed rule. We are submitting separate comments on the rule's inpatient PPS and Transforming Episode Accountability Model proposals.

AHA has serious concerns about this year's proposed payment updates for LTCHs. First, as AHA demonstrates, market basket updates have lagged real inflation for numerous consecutive years. In addition, the sharp rise in the fixed-loss amount for outlier payments has forced LTCHs to absorb hundreds of millions in losses for treating high-acuity patients. The combination of these factors, and the difficult inflationary environment facing hospitals, is seriously jeopardizing access for severely ill patients. AHA urges CMS to take action to address these issues and provides specific recommendations below.

PROPOSED FY 2025 LTCH PPS PAYMENT UPDATES

CMS proposes a market basket update of 3.2%, reduced by a productivity adjustment of 0.4 percentage points, resulting in a net market basket update of 2.8% for FY 2025. However, as discussed further below, overall payments to LTCHs would be severely reduced overall due to a proposed increase in the high-cost outlier (HCO) fixed-loss amount. As such, CMS projects an overall increase in standard payments of just 1.2% for FY 2025. **The AHA is critically concerned about these inadequate updates for FY 2025, which seriously risk jeopardizing access to needed care for some of Medicare's most severely ill beneficiaries.**

Impact of Inflation and Dual-rate Payment System on LTCHs

Rising inflation, the dual-rate payment system and other market dynamics have reshaped the LTCH landscape over the last several years. LTCHs have faced sharp increases in costs, especially for labor, supplies and drugs. In addition, the LTCH PPS dual-rate payment system and other factors have dramatically reduced patient volume and payments for these providers.

Inflation Has Put Serious Pressure on LTCH Operations. As with other hospitals, LTCHs have seen dramatic increases in costs over the last four years. This includes rising costs for labor, supplies and drugs, and administrative burdens. Indeed, a recent report from the AHA found that hospital employee compensation has grown by 45% since 2014.[1] This contrasts with total inflation, which only grew by 28.7% in that time. Labor-related inflation has been driven in large part by a severe workforce shortage, which the Department of Health and Human Services (HHS) says will persist well into the future.[2] Indeed, McKinsey found that resignations per month among health care workers grew 50% from 2020 through 2023.[3] Because of this, hospitals are turning to pricey contract labor to sustain operations which increased in cost by 258% from 2019 through 2023.[4] These increased costs are felt acutely by LTCHs as they struggle to maintain highly skilled staff in the form of nurses, therapists, physicians and other critical personnel.

Drug and supply costs also have pressured hospital operations due to disruptions in the supply chain and other factors. In fact, HHS found that prices for nearly 2,000 drugs increased an average of 15.2% from 2017 through 2023, notably faster than the rate of

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[1] https://www.aha.org/system/files/media/file/2024/05/Americas-Hospitals-and-Health-Systems-Continue-to-Face-Escalating-Operational-Costs-and-Economic-Pressures.pdf
[2] ASPE Office of Health Policy, Impact of the COVID-19 Pandemic on the Hospital and Outpatient Clinician Workforce, HP-2022-13 at 1 (May 3, 2022).
[3] McKinsey & Company. (Sept. 2023). How Health Systems and Educators Can Work to Close the Talent Gap, https://www.mckinsey.com/industries/healthcare/our-insights/how-health-systems-and-educators-can-work-to-close-the-talent-gap.
[4] Syntellis and AHA, Hospital Vitals: Financial and Operational Trends. (Last visited May 8, 2023), https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2_Feb%202023.pdf.

general inflation.[5] In addition, the American Society of Health System Pharmacists has found that numerous drug shortages are having a significant negative impact on hospital operations.[6] Further, LTCHs and other hospitals rely on a wide range of medical supplies ranging from protective equipment to ventilators. The AHA has found that hospital costs for supplies such as these increased by $6.6 billion in 2023 alone.[7]

Administrative costs also have risen sharply for LTCHs in recent years due to burdensome and unnecessary Medicare Advantage (MA) and commercial insurer practices. A study by the HHS Office of Inspector General found that post-acute care prior authorization requests were being denied inappropriately and that LTCHs and other hospitals were being forced to spend time and resources appealing erroneous denials.[8] Supporting this, McKinsey estimated that hospitals spent $10 billion annually dealing with insurer prior authorizations, and a 2023 study by Premier found that hospitals are spending just under $20 billion annually appealing denials.[9] Despite recent efforts by CMS, LTCHs report there has not been any relief from these practices in 2024, and hospitals and systems will need to continue to devote considerable resources toward them for the foreseeable future.

In addition to payer requirements, cybersecurity is another mounting administrative cost for hospitals. As CMS is aware, the recent cyberattack on Change Healthcare is deemed the most significant attack ever on the nation's health care system. In addition to the immediate disruption to hospitals' cashflow and operations, hospitals have devoted considerable resources to protecting patient and hospital information. Therefore, while they are expected to share more and more information with each other and with payers, they are also being forced to do so with increasing levels of security, which will continue to require more and more resources.

These escalating costs for essential clinicians, personnel, drugs, supplies, and other items and services have put a strain on the entire health care continuum. In all, Kaufman Hall found that total expenses have risen by 18% for hospitals compared to

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[5] ASPE. (Oct. 2023). Changes in the List Prices of Prescription Drugs, 2017-2023. https://aspe.hhs.gov/reports/changes-list-prices-prescription-drugs

[6] https://news.ashp.org/-/media/assets/drug-shortages/docs/ASHP-2023-Drug-Shortages-Survey-Report.pdf

[7] https://www.aha.org/system/files/media/file/2024/05/Americas-Hospitals-and-Health-Systems-Continue-to-Face-Escalating-Operational-Costs-and-Economic-Pressures.pdf

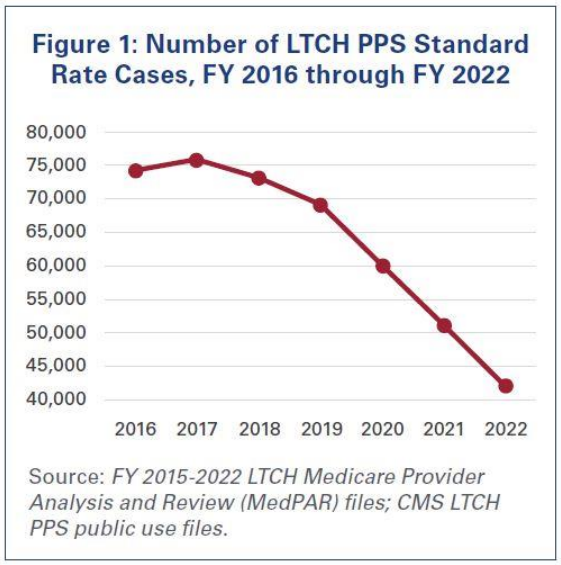
[8] DHHS OIG. (2023). High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care. https://oig.hhs.gov/oei/reports/OEI-09-19-00350.pdf

[9] McKinsey & Company. (2021). Administrative Simplification: How to Save a Quarter-Trillion Dollars in US Healthcare. https://www.mckinsey.com/~/media/mckinsey/industries/healthcare%20systems%20and%20services/our%20insights/administrative%20simplification%20how%20to%20save%20a%20quarter%20trillion%20dollars%20in%20us%20healthcare/administrative-simplification-how-to-save-a-quarter-trillion-dollars-in-us-healthcare.pdf

2021.[10] This is felt keenly by LTCHs, who care for the highest acuity patients with unique needs.

The Dual-rate Payment System and Other Dynamics Have Reshaped the LTCH Sector. As AHA spotlighted in a recent report and in previous correspondence with CMS, the LTCH sector and the patient population it serves has undergone drastic changes over the last decade due to the implementation of the LTCH dual-rate payment system and other market dynamics.[11] This includes sharp decline in patient volume, consolidated diagnosis-related groups (DRGs), a higher pool of patients enrolled in MA, and the resulting worsening financial situation.

For example, since implementation of the dual-rate payment system in FY 2016, the volume of standard rate LTCH cases has fallen by over 40%, from 74,294 in FY 2016 to 42,132 in FY 2022 (see Figure 1). Further, the total number of LTCH cases has fallen by approximately 70% from its peak under the legacy payment system. At the same time that patient volume is shrinking, the remaining patient pool is notably more acute and costly to treat. Further, the shrinking patient pool has led to significant consolidation into a relatively small number of LTCH PPS DRGs. Ten DRGs now account for more than half of all LTCH cases.[12] However, within these DRGs, there is great variation in patient severity and therefore in actual cost. Thus, cases are incresingly qualifying for high cost outlier (HCO) payments to compensate for lack of precision in the DRGs, as discussed more below.



In addition to a shrinking patient pool, approximately one-third of all Medicare LTCH discharges nationally are paid the inpatient PPS-equivalent rate. However, these reimbursements fall well short of the cost of care. Specifically, AHA's analysis shows that as of FY 2020 reimbursement for these cases totaled only 46% of the cost of care.[13] This is largely driven by the fact that these cases are not actually comparable to those treated in inpatient PPS hospitals. For example, AHA's analysis showed that of

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[10] https://www.kaufmanhall.com/sites/default/files/2024-05/KH-NHFR_2024-04.pdf
[11] https://www.aha.org/white-papers/2023-12-29-white-paper-medicares-ltch-outlier-policy-needs-reforms-protect-extremely-ill-beneficiaries
[12] Medicare Payment Advisory Commission, Health Care Spending and the Medicare Program, July 2023 https://www.medpac.gov/wp-content/uploads/2023/07/July2023_MedPAC_DataBook_SEC.pdf.
[13] https://www.aha.org/system/files/media/file/2019/06/aha-cms-long-term-care-proposed-rule-fy2020-6-21-2019_0.pdf

inpatient PPS claims with three days or more in the ICU, the average length of stay (ALOS) was approximately *four* days. However, the ALOS for inpatient PPS-equivalent cases in LTCHs was *23* days. Further, only 16% of inpatient PPS claims had patients with five or more complication or comorbidities (CCs) or major CCs, while 41% fell in that category for LTCH inpatient PPS-equivalent cases.

As noted, the growth of MA has also contributed to financial instability in the LTCH field. In addition to the unnecessary administrative costs discussed above, the share of Medicare beneficiaries enrolled in MA has grown by 54% since 2016. As of 2023, more than half of all Medicare beneficiaries are now enrolled in the program, and projections estimate it will continue to grow. These large commercial MA plans often inappropriately deny beneficiaries access to LTCH care, and those patients approved by MA plans for LTCH admission are often of higher acuity.[14] Indeed, while about half of Medicare beneficiaries were enrolled in MA in 2022, only about 31% of LTCHs' Medicare discharges were for MA beneficiaries.[15] This has further shrunk the LTCH patient population pool, resulting in sicker and outlier patients making up a higher proportion of total patients.

These market dynamics have all resulted in a marked shift in the financial status of the LTCH field. From FY 2011 through FY 2013, LTCHs' aggregate average Medicare margin ranged from 6.6% to 7.4%.[16] However, from FY 2017 through FY 2019, that margin fell substantially, ranging from -0.5% to -2.2%.[17] While the years during the pandemic saw a return to positive margins, this is attributable to the temporary suspension of the dual-rate payment system by Congress, which has since expired.

Adjustments to Market Basket Forecasts and Updates Are Needed

During this period of exploding cost growth and fundamental changes in the LTCH patient population and reimbursement, Medicare's market basket updates have now shown a consistent pattern of failing to not only accurately forecast, but also eventually capture these dynamics; FY 2022 being the most notable. In fact, despite the high rates of medical inflation, LTCH updates have not even kept up with general inflation. Since fee-for-service Medicare patients make up more than half of all LTCH discharges, and other insurers adjust payment relative to Medicare reimbursement, these missed forecasts compound the obstacles facing LTCHs. **We therefore urge CMS to use its**

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[14] HHS, Office of Inspector General (OIG); Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care (April 2022), https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf.
[15] Data from Strata Decision Technology, a health care technology and consulting firm, https://www.stratadecision.com/company/.
[16] MedPAC, March 2015 Report to Congress, Ch. 11, pg. 275, https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/chapter-11-long-term-care-hospital-services-march-2015-report-.pdf.
[17] MedPAC March 2022 Report to Congress Chapter 11, pg. 351, https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch10_SEC.pdf.

broad statutory authority to regulate LTCH payments to make a one-time adjustment to the LTCH standard payment rate to account for the FY 2022 market basket shortfall.

Since the COVID-19 public health emergency, IHS Global, Inc.'s (IGI's) forecasted growth for the LTCH market basket has consistently under-forecasted actual market basket growth. Specifically, there have now been four consecutive years of missed forecasts to LTCHs' detriment, beginning in FY 2021 (see Table 1). This has resulted in underpayments to LTCHs of 4.3%. While AHA is cognizant of the fact that forecasts will always be imperfect, in the past they have been more balanced. With four straight years of under-forecasts, AHA is concerned that there is a more systemic issue with IGI's forecasting.

Table 1: LTCH Market Basket Updates, FY 2021 through FY 2024

Year	FY 2021	FY 2022	FY 2023	FY 2024	Total
Market Basket Update in Final Rule	2.3%	2.6%	4.1%	3.5%	12.5%
Actual/Updated Market Basket	2.8%	5.5%	4.8%	3.7%	16.8%
Difference in Net Market Basket Update and Actual Increase	**-0.5%**	**-2.9%**	**-0.7%**	**-0.2%**	**-4.3%**

These missed forecasts have a significant and permanent impact on LTCHs. For example, a cumulative underpayment of 4.3 percentage points totals more than $130 million in underpayments to LTCHs annually. Further, and as CMS knows, future updates are based on current payment levels. Therefore, absent action from CMS, these missed forecasts are permanently established in the standard payment rate and will continue to compound. In addition, these underpayments also influence other payments, including for the growing MA patient population.

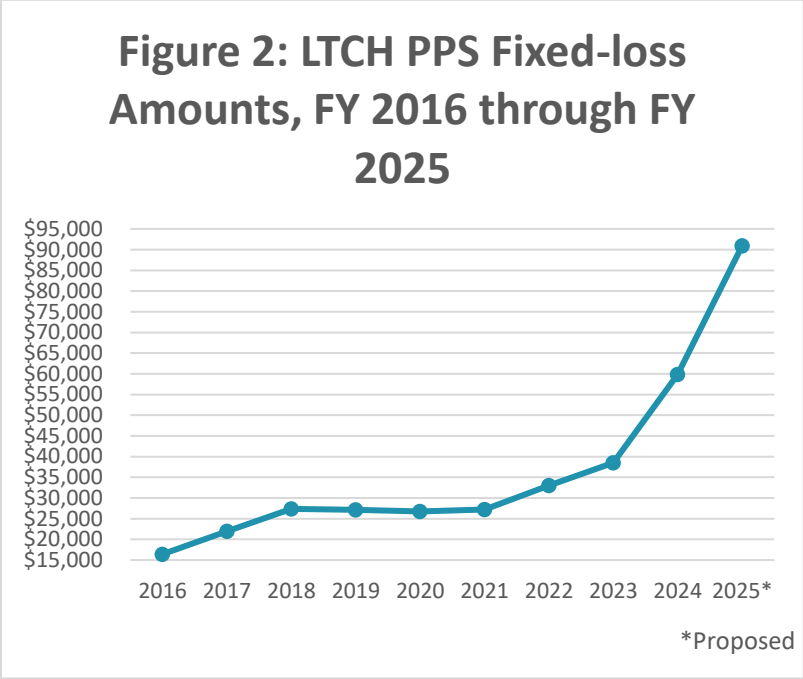
In addition to inaccurate forecasts, the underlying market basket itself may have shortcomings that fail to properly capture expense growth. As explained above, there has been very large growth in LTCH and other hospitals' costs in the last several years. This has exceeded general inflation, which totaled 16.8% from 2021 to 2023 according to the CPI-U.[18] However, even actual market basket growth (not forecasts) totaled only 13.1% during this time. **It is confounding to AHA how hospitals, particularly those serving the most severely ill patients, could have a market basket that is significantly below general inflation.**

[18] https://www.bls.gov/regions/mid-atlantic/data/consumerpriceindexannualandsemiannual_table.htm

There are likely many and overlapping contributing factors to the market basket failing to capture inflationary factors. As AHA noted in prior comment letters, one such factor may be CMS' use of the Employment Cost Index (ECI) to measure changes in labor compensation in the market basket.[19] By design, the ECI cannot capture changes in costs driven by shifts between different categories of labor, which CMS itself recognizes.[20] Yet, one major change over the last several years has been increased utilization in contract labor. Therefore, the ECI may not be adequately capturing growth in the costs of employment and labor. However, this is just one example of a potential issue, and we encourage CMS to thoroughly reexamine the market basket and its recent shortcomings to identify other potential areas for refinement. AHA stands ready to work with CMS to assist with such an endeavor. To that end, AHA also requests that CMS publish additional information and underlying data regarding its methodology, as AHA and its members have been unable to replicate some of CMS' figures.

Adjustments to Proposed HCO Fixed-loss Amount Are Necessary

For FY 2025, CMS is proposing to increase the HCO fixed-loss amount (FLA) from $59,873 to $90,921, a staggering 52% increase. However, the agency also stated that it is considering an alternative one-year transitional FLA of $75,397. **AHA greatly appreciates that CMS recognizes the risk posed by the sharp increases in the FLA in recent years. To that end, we have several suggestions that would help mitigate these risks. Adopting these alternatives would help ensure continued access to care for patients in need of LTCH services.** In addition, it also will help avoid disruptions

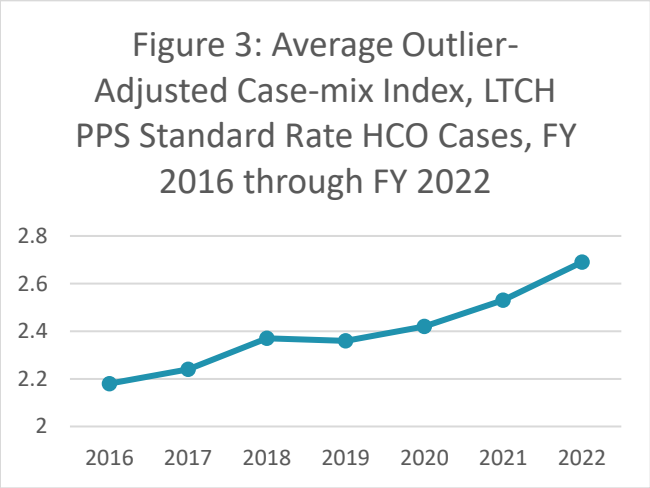


[19] 86 Fed. Reg. 25401 (May 10, 2021). "We use the ECI because it reflects the price increase associated with total compensation (salaries plus fringes) rather than just the increase in salaries. In addition, the ECI includes managers as well as other hospital workers. This methodology to compute the monthly update factors uses actual quarterly ECI data and assures that the update factors match the actual quarterly and annual percent changes."

[20] 86 Fed. Reg. 25421 (May 10, 2021). CMS stated that ECI measures "the change in wage rates and employee benefits per hour… [and are superior] because they are not affected by shifts in occupation or industry mix."

to other sites of care that rely on LTCHs. For example, decreased access to LTCH services directly impacts short-term acute care hospitals, which will be required to care for these patients longer than they otherwise would in their intensive care unit and other departments.

Background on the Rising Fixed-Loss Amount. AHA agrees with the stated purpose of the HCO policy, which is to "reduce the financial losses that would otherwise be incurred by hospitals when treating patients who require more costly care and, therefore, reduce the incentives to underserve these patients."[21] **However, clearly the HCO policy has become inadequate to meet this purpose.** Even CMS' proposed alternative FLA of $75,397 would represent a 360% increase in the FLA from FY 2016 through FY 2025. This seriously threatens access for the sickest of sick Medicare beneficiaries — those requiring long stays in LTCHs.



AHA detailed the underlying causes and the impacts of the rising FLA in our recent white paper. As explained above, LTCH volume has dropped severely since the implementation of the dual-rate payment system. In accordance with this volume decrease, the acuity of cases under the dual-rate payment system has increased, making the average case more costly. Specifically, the acuity of HCO cases (as measured by their "outlier-adjusted" case-mix index (CMI)) has increased by 23%, from 2.18 in FY 2016 to 2.69 in FY 2022 (see Figure 3).[22] By comparison, the average outlier-adjusted CMI of all standard-rate cases in FY 2022 was 1.44.[23]

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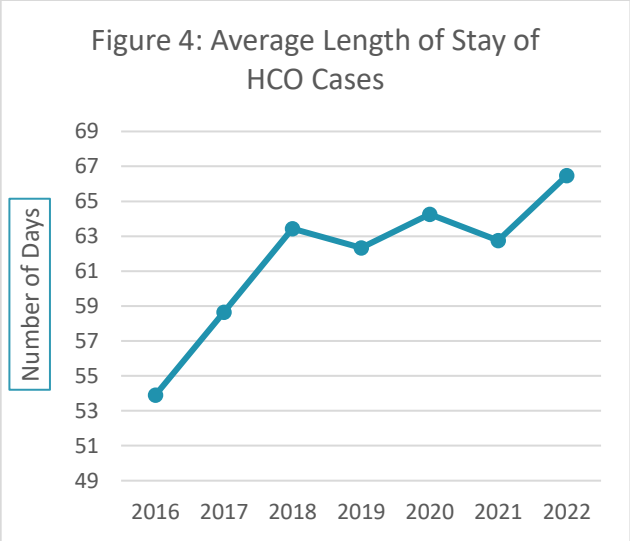
[21] Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates; 80 Fed. Reg. 49325, 49,617 (Aug. 17, 2015).

[22] To calculate the outlier-adjusted CMI, we use the same concept as what CMS presents in the LTCH impact files. We multiply the MS-LTC-DRG service intensity weights by an adjustment factor calculated as the total estimated LTCH PPS payment amount (including the outlier amount) divided by the estimated "inlier" payment amount (the payment amount excluding the outlier payment). An HCO case would then have a higher adjusted weight than a non-HCO case since its adjustment factor would be greater than 1, reflecting the higher service intensity not captured in base DRG payments. The outlier-adjusted CMI is then calculated as the average of the adjusted MS-LTC-DRG weights.

[23] FY 2015-2022 LTCH MedPAR files; CMS LTCH PPS public use files.

Similarly, the ALOS for HCO cases has also increased, by 23%, from 53.9 days in FY 2016 to 66.47 days in FY 2022 (see Figure 4). By comparison, the ALOS for all standard rate cases in FY 2022 was 29 days.[24] This rising acuity (and therefore cost of caring) has resulted in many cases that once would have qualified for an HCO payment now falling well below the threshold. Thus, LTCHs must now absorb additional losses for 1) cases that would have previously qualified for HCO payment with a lower FLA but no longer do, and 2) cases that do qualify for HCO payment, but require LTCHs to absorb a much higher loss due to the increased FLA.



The decreasing number of LTCH cases is also leading to their significant consolidation into a relatively small number of LTCH PPS DRGs. Specifically, analysis shows that the top five DRGs by volume — 189, 207, 166, 871 and 981 — make up more than half of all LTCH cases, and 189 and 207 alone make up more than 40% of all cases. However, within these cases, there is great variation in patient severity, and therefore in actual cost. The lack of precision in payment for these cases leads to a notable number of them qualifying for HCO payments because the DRG payment is not sufficient. Indeed, DRGs 189, 207, 166 and 981 collectively made up $134 million out of the $187.7 million in outlier payments made in FY 2023.

These phenomena are not surprising to providers who cautioned the dual-rate payment system would have such an effect. Indeed, in the FY 2016 and 2017 rulemakings, CMS noted increases in the FLA and said it believed that it was due to the new dual-rate payment system. [25] However, it stated that it "expect[s] annual changes to the fixed-loss amount to generally stabilize as experience is gained under the new dual rate LTCH PPS payment structure."[26] However, that stabilization never materialized.

The staggering losses LTCHs must absorb on HCO cases play an outsized role in hospitals' overall financial instability. Even with the lower FLA of $75,397, LTCHs would be forced to absorb additional losses of $311 million dollars annually compared to the

[24] FY 2015-2022 LTCH MedPAR files; CMS LTCH PPS public use files.
[25] FY 2016 IPPS/LTCH PPS Final Rule, 80 Fed. Reg. 49326, 49621 (Aug. 17, 2015).
[26] FY 2017 IPPS/LTCH PPS Final Rule, 81 Fed. Reg. 56762, 57305 (Aug. 22, 2016).

FLA prior to the dual-rate payment system.[27] This is an unsustainable figure that will force LTCHs to make difficult decisions about continuing to care for select patients.

Recommendation #1: Permanent Annual Cap on Changes to the FLA. As CMS has recognized, stability and predictability are essential for providers. However, the 265% increase in the FLA from FY 2016 through FY 2024 has been very destabilizing and warrants immediate action, especially given its continued significant proposed increase for FY 2025. **AHA therefore urges CMS to adopt a cap on any year-to-year changes in the FLA.**

In its FY 2023 rulemaking, CMS proposed and finalized a policy for a permanent 10-percent cap on any decreases to weights for MS-DRGs. CMS stated that such a cap was appropriate "in order to promote predictability and stability in hospital payments and to mitigate the financial impacts of significant fluctuations in the weights. That is, by smoothing year-to-year changes in the MS-DRG relative weights, this proposed policy would provide greater predictability to hospitals, allowing time to adjust to significant changes to relative weight."[28] Similarly, CMS also finalized a permanent cap of 5% for any changes to LTCHs wage index from year to year. In finalizing that policy, CMS stated this policy "would provide greater predictability to LTCHs. That is, the policy would smooth year-to-year changes in LTCHs' wage indexes and provide for increased predictability in their wage index and thus their LTCH PPS payments."[29]

A 10% or similar cap on changes in the FLA would similarly help provide stability and predictability. Of course, in this case, a cap would be placed only on any *increases* to FLA, since increases are what translate to lower payments to providers. Indeed, outlier payments are a prime example of a part of the payment system that may be subject to wide year-to-year changes due to the low-volume nature of the claims. Further, as CMS has noted in this rulemaking, it believes the budget neutrality requirement for the LTCH PPS HCO policy "applies only to the first year of the implementation of the LTCH PPS (that is, FY 2003)." Therefore, in implementing such a policy, CMS would not be required to further reduce payments to account for this adjustment.

Recommendation #2: Extended Transition for FLA. AHA appreciates the alternative FLA amount considered by CMS as a one-year transition. However, as mentioned above, increasing the FLA to $75,397 would still be a one-year increase of 26%, after already receiving a 265% increase from FY 2016 through FY 2024. **Therefore, consistent with CMS' stated concern of how the FLA might impact LTCH operations, CMS should**

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[27] Based on 2022 outlier volume, the total losses for FY 2016 would be approximately $87 million (5,275 cases X $16,423), and the total losses for FY 2025 would be approximately $398 million (5,275 cases X $75,397).
[28] Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates; 87 Fed. Reg. 28,108, 28,202 (May 10, 2022) (https://www.federalregister.gov/documents/2022/05/10/2022-08268/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the).
[29] *Ibid*. at 28,685

extend this transition to at least four years. Doing so would allow the FLA to rise by approximately $7,800 per year for four years, or an annual increase of about 13%. This extended transition would again be consistent with multiple policies CMS has implemented in the name of smoothing transitions for providers.

Use of this extended transition policy also would be prudent due to the instability created by the COVID-19 public health emergency (PHE). Specifically, CMS is proposing to use claims data from Oct. 1, 2022, to Sept. 30, 2023, and cost report data from Oct. 1, 2021, through Sept. 30, 2022, in calculating the FY 2025 FLA. This data is heavily skewed by the PHE, which didn't officially end until May 2023. Further, the highest rates of hospitalizations occurred in early 2022. Therefore, transitioning over several years will allow CMS to determine whether the FLA may be able to return to prior levels, or if a longer-term solution may be needed.

Recommendation #3: Utilize a Market Basket Based Methodology. Until FY 2022, CMS calculated the FLA by forecasting growth in charges using the market basket for LTCHs. It did this because indexing the charge growth to market basket growth helped ensure the FLA grew consistent with payment. However, in FY 2022 the agency began utilizing a methodology that forecasts growth in charges using claims data. When CMS made the change, the field warned it would lead to volatility, and indeed, these concerns have borne out as noted above.

In addition to creating more instability for providers, the new claims-based methodology has proven to be inaccurate. For example, CMS states that for FY 2024 the FLA would have needed to be set at $72,275 for CMS to hit its outlier target. However, in the proposed rulemaking for FY 2024, the claims-based methodology resulted in CMS proposing a FLA of $94,378.[30] Further, CMS now estimates that for CMS to have hit its outlier target in FY 2023, the FLA would have needed to have been set at $65,260.[31] However, in the proposed rulemaking for FY 2023, the claims-based methodology resulted in CMS proposing a FLA of $44,182.[32] In both cases, the proposed FLA was inaccurate by more than $20,000.

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[30] CMS ultimately deviated from the current methodology due to the PHE, but this nonetheless demonstrates the inaccuracies associated with this methodology.

[31] Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes; 89 Fed. Reg. 35,934, 36,592 (May 2, 2024). (https://www.federalregister.gov/documents/2024/05/02/2024-07567/medicare-and-medicaid-programs-and-the-childrens-health-insurance-program-hospital-inpatient).

[32] Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates; 87 Fed. Reg. 28,108, 28,692 (May 10, 2022) (https://www.federalregister.gov/documents/2022/05/10/2022-08268/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the).

Due to the inaccuracy of this claims-based methodology, and the instability it creates for providers, AHA encourages CMS to revert to its previous, market-basket based methodology for forecasting charges as part of its HCO methodology. This suggestion could be adopted in conjunction with the first recommendation, so that in addition to the use of the previously used methodology, providers would still have additional predictability in the form of a 10% cap on any increases to the FLA. Alternatively, it could also be paired with the second recommendation, so any increase in the FLA using the previously used methodology would be implemented over a set number of years.

Recommendation #4: Further Refine Data Used in HCO Methodology. There are several other steps CMS can take to improve the methodology used to set the FLA. First, CMS currently only uses data through March in its methodology. However, AHA analysis has found that utilizing more recent data, such as cost reports with a July 31 cutoff date, results in a more accurate (and usually lower) FLA. **Therefore, AHA encourages CMS to utilize more recent data in its methodology.**

In addition, as AHA pointed out in last year's comment letter, LTCHs are facing increasing challenges in caring for dialysis patients.[33] Specifically, hospitals report there is still an acute shortage of outpatient dialysis providers and sub-acute facilities willing or able to take patients with dialysis needs. In addition to the notable extra costs of caring for these patients, the patients also are being forced to remain in the LTCH longer than needed because a proper outpatient or sub-acute placement is not available in a timely manner. **Consistent with other aberrations where CMS has trimmed data, we urge the agency to likewise trim dialysis patients from the data used to calculate the FLA, even if just temporarily.** Doing so will allow for a more accurate forecast of what costs and charges will look like as the provider shortage dissipates and provide additional predictability for providers.

Recommendation #5: Modify Select DRGs to Improve the Accuracy of Payments. As AHA explained above, there has been consolidation of LTCH patients into a small number of DRGs. These DRGs are contributing significantly to the amount of outlier payments being made due to wide variation in cost in the patients they include. **Refining these DRGs to capture additional clinical nuance and adjusting payment accordingly would improve the accuracy of the LTCH PPS.** In addition, by ensuring these DRG payments more closely match cost, less cases will qualify for outlier payment, helping to limit further growth in the FLA.

Recommendation #6: Transmittal 12594 Should Be Rescinded. On April 26, 2024, CMS issued Transmittal 12594 regarding outlier reconciliation under the inpatient PPS and LTCH PPS.[34] In this transmittal, CMS changed the threshold and criteria for a facility to

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[33] https://www.aha.org/lettercomment/2023-06-09-aha-comment-letter-long-term-care-facility-pps
[34] https://www.cms.gov/files/document/r12594cp.pdf

qualify for outlier reconciliation. As CMS knows, this will subject many additional facilities to the reconciliation process — a process that is already backlogged and takes several years to complete. It also will further strain LTCHs who are already taking deep losses on their outlier cases. In addition, this is a substantive change to CMS' payment policy, which is subject to notice and comment rulemaking under the Medicare statute. **Therefore, we urge CMS to withdraw the transmittal.** To the extent CMS wishes to implement this policy, it must be done through notice and comment rulemaking.

LTCH Quality Reporting Program

Proposed Adoption of Four New Standardized Patient Assessment Data Elements. Beginning with the FY 2028 LTCH Quality Reporting Program (QRP), CMS proposes to require LTCHs to report four new standardized patient assessment data elements (SPADEs) under the social determinants of health (SDOH) domain. In its proposal, CMS states that the new SPADEs address health-related social needs (HRSN) not already captured by the existing SDOH elements and include food security, living situation and utility difficulties. The AHA shares CMS' goal of advancing health equity and recognizes the value that screening for HRSNs can play in identifying barriers to achieving the best outcomes for all patients. However, we are concerned that the proposed new SPADEs are not well-aligned with similar HRSN reporting requirements across the care continuum. We also believe the proposed SPADEs need further testing and refinement to ensure they work as intended in the LTCH setting.

In its proposal, CMS states that it believes these new requirements would "further standardized the screening of SDOH across quality programs," citing the recently adopted quality measures in the Inpatient and Inpatient Psychiatric QRPs that assess whether facilities have screened patients for housing instability, food insecurity, utility difficulties, transportation needs and interpersonal safety. Indeed, CMS states that it believes "using common standards and definitions for new items is important to promote interoperable exchange of longitudinal information between LTCHs and other providers to facilitate coordinated care, continuity in care planning, and the discharge planning process."

While the proposed SPADEs do address some (but not all, like interpersonal safety) of the same HRSNs addressed by the screening measures, the proposed requirements are hardly standardized with those in the Inpatient and Inpatient Psychiatric Facility QRPs. The proposed SPADEs are adapted from the Accountable Health Communities (AHC) HRSN Screening Tool developed for the AHC model; CMS is dictating precisely when and how (that is, asking questions with specific wording during the initial admission assessment) LTCHs are to assess patients for these HRSNs. However, inpatient acute care hospitals and psychiatric facilities may use any "standardized HRSN screening" and are only asked to document that a patient was screened, not when or how. In other words, these proposals are unlikely to produce the interoperable data CMS believes they will.

Further, the AHA raises some concerns with the elements themselves. In implementing the AHC HRSN screening tool in the AHC model, CMS directs users to follow specific protocols to determine a patient's eligibility for completing the tool, select domains for use in their communities, and score patient responses to determine next steps. In this proposed rule, CMS merely picks a few questions from the tool and plants them in the Minimum Data Set (MDS) without much guidance. The AHA is concerned that it will be challenging to glean accurate responses to the AHC items from the LTCH patient population, considering that LTCH patients and residents are more severely ill than the average Medicare beneficiary for which the screening tool was developed. For example, the food security questions ask patients to rate the frequency of food shortages using a three-point scale, whereas other questions on the MDS, such as the resident mood (PHQ-9 tool), behavioral symptoms and daily preferences items, use a four-point scale to determine frequency. These discrepancies might make it difficult for staff to administer the SPADEs, and given the inconsistency with the scales used in other MDS items, it may lead to confusion for staff and patients alike. In addition, there is no skip logic included for these questions as there are for other MDS items. If a patient reports that they do not have a stable place to live in response to the living situation item, it seems inappropriate to subsequently ask them about their utility difficulties.

Overall, the AHA questions the utility of including these items in the MDS. While we agree that LTCHs — and other health care facilities and providers — should consider their patients' and residents' HRSN in their care, CMS' evaluation of the use of the AHC HRSN screening tool in the model showed that it "did not appear to increase beneficiaries' connection to community services or HRSN resolution."[35] At a minimum, we believe the proposed new SPADEs need further testing and clearer implementation guidance before CMS adopts them for the LTCH QRP.

Lastly, we also request that CMS articulate its vision of how HRSN information collected in the SPADEs will be used in its quality and payment programs. While CMS appears to be focused for now on HRSN screening, there is evidence that CMS is considering even farther-reaching approaches to holding LTCHs and other health care providers accountable for addressing HRSNs. For example, CMS also is considering measures that assess connections to community providers and the resolution of HRSNs following care.[36] We believe that those measures would inappropriately hold LTCHs and other health care providers solely accountable for social drivers of health that require resources and engagement across an entire community to address. We are concerned that CMS may implement such measures in the LTCH QRP in the future, using its SPADE collection process as the mechanism to collect measure data. Holding LTCHs solely accountable for community-based outcomes is far outside of the scope of these facilities.

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[35] https://www.cms.gov/priorities/innovation/data-and-reports/2023/ahc-second-eval-rpt-fg
[36] http://mmshub.cms.gov/news-events/2023-measures-under-consideration-list-now-available

Proposed Extension of Admission Assessment Window. Beginning with the FY 2028 LTCH QRP, CMS proposes to expand from three to four days the period in which LTCHs must administer the local coverage determinations (LCDS) following admission. **The AHA supports this extension.** Patient assessments are extremely time consuming, especially considering the great length of the LCDS tool. We and other stakeholders have raised this concern, as it is difficult — and, frankly, not in the best interest of the patient — to rush through an assessment to meet the arbitrary time limit, particularly for patients who demonstrate complex illness or who are transferred during evenings or weekends when there may be fewer administrative staff to assist with admission paperwork.

Request for Information (RFI): Future LTCH Star Rating System. CMS seeks public comment on the development of a five-star quality rating methodology for LTCHs. Specifically, CMS requests feedback on any specific criteria CMS should use to select measures for an LTCH star rating system, and how the agency should present LTCH star rating information in a way useful to consumers.

As longstanding supporters of quality transparency, the AHA shares CMS' goal of giving patients meaningful, accurate and understandable information about the quality of care in LTCHs and other health care facilities. Our response to this RFI is heavily influenced by our experience with the Hospital Star Ratings Program, which has undergone significant changes over the past few years due to inadequacies in its initial design. This program, or a future LTCH Star Rating System, is just one of several sources of data and rankings on facility performance. As with any report cards or ratings, each must be interpreted in context, and it is unlikely that any single rating will provide a robust and reliable portrait of quality in a facility.

The premise of a star rating or any other composite quality ranking or rating is that available measures lend themselves to a fully representative quality score relevant to all patients. Yet, the measures available in the LTCH QRP were never selected to create this holistic picture. The measures reflect highly specific aspects of care delivered in LTCHs and have been added to the program to achieve disparate goals, ranging from agency priorities to statutory requirements (e.g., the Improving Medicare Post-Acute Care Transformation Act directive for standardized and interoperable measures across post-acute care settings). As a result, an overall rating may reflect performance on measures that are irrelevant to the reasons a patient is seeking care.

Furthermore, we are concerned that the issues regarding statistical validity with the Hospital Star Ratings Program, as well as the ability for consumers to use it to inform decision-making, would be exacerbated due to the nature of the LTCH QRP measures. CMS quality measure data that goes into the Star Ratings is often several years old, which lessens its utility in evaluating the quality of care in the present. The limited scope and breadth of measures available in the LTCH QRP and the often low volumes that LTCHs report — would make data reliability and developing a truly representative overall star rating even more challenging. The LTCH QRP will consist of just 17

measures beginning FY 2025, and LTCHs provide about 400,000 stays per year (according to MedPAC), whereas the Hospital Star Ratings Program uses data from over 40 measures across more than 7.5 million inpatient stays and 78.1 million outpatient visits. In other words, if we and others have concerns about how well the Hospital Star Ratings Program represents the totality care delivered in hospitals, it is hard to conceptualize the utility of an LTCH star ratings program based on a small fraction of measures and patient episodes.

If CMS does develop an LTCH Star Rating methodology, the AHA submits the following recommendations. First, we recommend that CMS provide LTCHs with feedback reports on claims-based measures on a quarterly basis, as it does for hospitals. Currently, LTCHs are not able to review this information at the patient level, and thus are limited in their ability to implement tailored improvements to the care they provide. Second, we recommend that CMS not include a rating of patient-reported experience of care in an LTCH Star Ratings program because implementing such a survey in the LTCH setting presents both conceptual and statistical reliability challenges. Patient experience during an LTCH stay is difficult to glean for this population, many of whom have undergone traumatic brain injuries and are relearning basic function. These patients may not be able to respond to patient experience questions in the same way as in general acute care. As a result, the reliability of a patient experience survey based on such a small number of responses would be extremely low.

RFI: Measure Concepts Under Consideration for Future Years. CMS seeks public comment on the importance, relevance, appropriateness and applicability of certain quality measure concepts for future use in the LTCH QRP.

Composite measure of overall immunization status. The AHA does not support this measure concept. The AHA strongly supports the vaccination of health care providers and communities against vaccine-preventable communicable diseases. However, the use of measures of immunization status — including the recently adopted COVID-19 Vaccination Among Patients or Residents measure — is inappropriate in the LTCH setting. Vaccination status among patients/residents is subject to many patient-level factors outside of the control of providers. For post-acute facilities and providers, it may be infeasible or inappropriate to offer vaccination for patients due to length of stay, ability to manage side effects and medical contraindications, or other logistical challenges with gathering information from a patient who may have received care from multiple proximal providers. Even without these challenges, however, patients/residents may choose to forgo vaccination despite a provider's best efforts. It is possible that a post-acute care facility could have a robust effort to encourage vaccination among their patients/residents but still have a relatively low rate of vaccination. As the Health Equity subcommittee of the National Quality Forum Measure Applications Partnership noted in its review of this measure, cultural norms often play a large role in vaccine confidence. While post-acute providers will always seek to counsel vaccination in a culturally sensitive way, they also want to honor the choice of their patients once they have offered their clinical advice.

Clinical Screening and Follow-up for Depression. In its RFI, CMS notes that it is considering a measure concept related to depression, which "may be similar" to a measure in CMS' Universal Foundation. We assume the agency is referencing to the measure used for the Hospital Inpatient QRP, Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan, which assesses the percentage of patients aged 12 years and older who are screened for clinical depression using an age-appropriate standardized depression screening tool and, if positive, a follow-up plan is documented. Considering that the LTCH patient assessment instrument already contains Patient Depression Questionnaire (PHQ-9), which serves to screen, diagnose, monitor and measure the severity of depression, an additional quality measure regarding depression screening would be redundant.

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

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development