Federal Fiscal Year 2020 Long-Term Care Hospital Prospective Payment System Final Rule

SUMMARY

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Long-Term Care Hospital Prospective Payment System (LTCH PPS)

A. Background

Since FY 2016, LTCHs have been paid under a dual-rate payment structure. An LTCH case is either paid at the "LTCH PPS standard federal payment" when the criteria for site neutral payment rate exclusion are met or a "site neutral payment rate" when the criteria are not met. Site neutral cases will be paid an IPPS comparable amount. The criteria for exclusion from the site neutral payment remain the same for FY 2020:

- Case cannot have a principal diagnosis relating to a psychiatric diagnosis or rehabilitation (the DRG criterion).
- Case must be immediately preceded by discharge from an acute care hospitalthat included at least 3 days in an intensive care unit (the ICU criterion).
- Case must be immediately preceded by discharge from an acute care hospital and the LTCH discharge must be assigned to an MS-LTC-DRG based on the beneficiary's receipt of at least 96 hours of ventilator services in the LTCH (the ventilatorcriterion).

To be paid the LTCH PPS standard federal payment, the case must meet the DRG criterion and either the ICU or ventilator criterion.

CMS finalizes payment updates for LTCHs using a process that is generally consistent with prior regulatory policy and that cross-links to relevant IPPS provisions. For FY 2016 and FY 2017, the site neutral payment rate was a blend of the LTCH PPS standard federal rate and the IPPS comparable amount. Section 51005 of the BBA 2018 extended the transitional blended payment rate (50 percent LTCH standard federal payment and 50 percent IPPS comparable amount) for site neutral payment cases for an additional 2 years. CMS made conforming changes to the regulations to implement the extended transitional blended payment.

Summary of Changes to LTCH PPS Rates for FY 2020*	
Standard Federal Rate, FY 2019	$41,558.68
Final Rule Update Factors	
Update as required by Section 1886(m)(3)(C) of the Act	+2.5%
Penalty for hospitals not reporting quality data	-2.0%
Net update, LTCHs reporting quality data	+2.5% (1.025)
Net update LTCHs not reporting quality data	0.5% (1.005)
Final Rule Adjustments	
Final average wage index budget neutrality adjustment	1.0020203
Final budget neutrality adjustment to eliminate the 25-percent threshold policy	0.999858
Final Standard Federal Rate, FY 2020	
LTCHs reporting quality data	$42,677.63
LTCHs not reporting quality data	$41,844.89
Final Fixed-loss Amount for High-Cost Outlier (HCO) Cases	
LTCH PPS standard federal payment rate cases	$26,778
Site neutral payment rate cases (same as the IPPS fixed-loss amount)	$26,473
Impact of Policy Changes on LTCH Payments in 2020	
Total estimated impact	1.0% ($43 million)
LTCH standard federal payment rate cases (71% of LTCH cases)	+2.7% (+$91 million)
Site neutral payment rate cases (29% of LTCH cases)**	-5.9% (-$49 million)
*More detail is available in Table IV "Impact of Payment Rate and Policy Changes to LTCH PPS Paymentsfor LTCH PPS Standard Federal Payment Rate Cases for FY 2020" on pages 2232-2233 of the display copy. Table IV does not include the impact of site neutral payment rate cases. **LTCH site neutral payment rate cases are paid a rate that is based on the lower of the IPPS comparable per diem amount or 100 percent of the estimated cost of the case.	

B. LTCH PPS MS-DRGs and Relative Weights

Background

Similar to FY 2019, the annual recalibration of the MS-LTC-DRG relative weights for FY 2020 is determined using data only from claims qualifying for LTCH PPS standard federal rate payment and claims that would have qualified if that rate had been in effect. Thereby, the MS-LTC-DRG relative weights are not used to determine the site neutral payment rate and site neutral payment case data are not used to develop the relative weights.

Patient Classification into MS-LTC-DRGs

CMS continues to apply the same MS-DRG classification system used for the IPPS payments to the LTCH PPS in the form of MS-LTC-DRGs. Other MS-DRG system updates are also incorporated into the MS-LTC-DRG system for FY 2020 since the two systems share an identical base. Finalized MS-DRG changes are described elsewhere in this summary and details can be found in section II.F. of the preamble.

Development of the MS-LTC-DRG Relative Weights

In developing the FY 2020 relative weights, CMS uses its current methodology and established policies related to the hospital-specific relative-value methodology, volume-related and monotonicity adjustments, and the steps for calculating the relative weights with a budget neutrality factor (described in more detail below).

Relative Weights Source Data

FY 2020 relative weights are derived from the March 2019 update of the FY 2018 MedPAR file. These data are filtered to identify LTCH cases meeting the established site neutral payment exclusion criteria (or would have met the exclusion criteria had the dual rate LTCH PPS payment structure been in effect at the time of discharge). The filtered data are trimmed to exclude all-inclusive rate providers, Medicare Advantage claims, and demonstration project participants, yielding the "applicable LTCH data." The applicable LTCH data are used with Version 37 of the GROUPER to calculate the final FY 2020 MS-LTC-DRG relative weights.

Hospital-Specific Relative-Value Methodology (HSRV)

CMS continues to use its HSRV methodology in FY 2020, unchanged from FY 2019, to mitigate relative weight distortions due to nonrandom case distribution across MS-LTC-DRGs and charge variation across providers. The HSRV methodology scales each LTCH's average relative charge value by its case mix.

Volume-related adjustments

CMS continues to account for low-volume MS-LTC-DRG cases as follows:

- If an MS-LTC-DRG has at least 25 cases, it is assigned its own relative weight.
- If an MS-LTC-DRG has 1-24 cases, it is assigned to one of five quintiles based on average charges CMS then determines a relative weight and average length of stay for each quintile; each quintile's weight and length of stay are then assigned to each MS-LTC-DRG within that quintile.
- If an MS-LTC-DRG has zero cases (i.e., no volume) after data trims are applied, it is cross-walked to another MS-LTC-DRG based on clinical similarities in resource use intensity and relative costliness in order to assign an appropriate relative weight. If the MS-LTC-DRG that is clinically similar is a low-volume DRG that has been assigned to one of the five quintiles noted above, then the no volume MS-LTC-DRG is assigned to that same quintile.

The low-volume quintiles and no-volume crosswalk data previously published in Tables 13A and 13B are now made available on the CMS website at http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html.

CMS assigns a 0.0 relative weight for eight transplant MS-LTC-DRGs since no LTCH has been certified by Medicare for transplantation coverage. CMS also will assign a 0.0 relative weight

for the 2 "error" MS-LTC-DRGs (998 and 999) which cannot be properly assigned to an MS-LTC-DRG group. CMS does not calculate a weight for the 15 psychiatric and rehabilitation MS-LTC-DRGs because these MS-LTC-DRGs would never include any LTCH cases meeting the site neutral payment rate exclusion criteria. However, to determine a transitional blended payment amount for FY 2020, CMS uses the FY 2015 relative weights for these MS-LTC-DRGs (as was done for FYs 2016- 2019).

Treatment of Severity Levels, Monotonicity Adjustments

Each MS-LTC-DRG contains one, two or three severity levels; resource utilization and relative weights typically increase with higher severity. For relative weights that decrease as severity increases in a DRG ("nonmonotonic"), CMS continues for FY 2020 its approach of combining severity levels within the nonmonotonic MS-LTC-DRG for purposes of computing a relative weight to assure that monotonicity is maintained.

Selected Steps for Determining the MS-LTC-DRG Relative Weights

CMS continues to calculate the relative weights by first removing cases with a length of stay of 7 days or less (Step 1) and then removing statistical outliers (Step 2). The effect of short stay outlier (SSO) cases (those with a length of stay of five-sixths or less of the average for that MS-LTC-DRG) is adjusted for by counting an SSO as a fraction of a discharge based on the ratio of the length of stay of the SSO case to the average length of stay for the MS-LTC-DRG for non-SSO cases (Step 3).

CMS applies its two-step methodology to achieve budget neutrality for the FY 2020 MS-LTC-DRG and relative weights update (Step 7). First, CMS calculates a normalization factor of 1.27367 that is applied to the recalculated relative weights to ensure that the recalibration does not change the average case mix index. Second, CMS calculates and applies a budget neutrality factor of 0.9959342 to each normalized relative weight.

Extensive discussion of the entire 7-step process to determine MS-LTC-DRG relative weights is provided in the final rule (pages 1,276 to 1,294 of the display copy). Table 11 (listed in section VI. of the Addendum to the final rule and also available on the CMS website) lists the MS-LTC-DRGs and their respective relative weights, geometric mean length of stay, and five-sixths of the geometric mean length of stay (used to identify SSO cases under § 412.529(a)) for FY 2020.

C. Payment Adjustment for LTCHs with Site Neutral Payments above a Threshold Percent

Background

An LTCH's "discharge payment percentage" is the ratio of its Medicare discharges paid at the LTCH PPS standard federal payment rate to the total number of Medicare FFS discharges paid under the LTCH PPS during the cost reporting period. CMS is required to inform an LTCH if its discharge payment percentage is not at least 50 percent beginning with FY 2016 cost reporting periods. For cost reporting periods beginning on or after October 1, 2019, CMS must notify the

LTCH it will be paid at IPPS comparable amounts for all discharges in subsequent years subject to the LTCH's compliance with a reinstatement process.

Notice and Payment Adjustment

CMS implemented the notice requirement in the FY 2016 IPPS/LTCH PPS final rule and established sub-regulatory policies and timeframes by which it calculates and informs LTCHs of their discharge payment percentage. In this final rule, CMS provides guidance for how it would implement the requirement to pay the IPPS comparable amount when the LTCH's discharge payment percentage exceeds 50 percent.

CMS clarifies that the discharge payment percentage is calculated based on the LTCH as a whole—not individual locations of the hospital. Responding to commenters' concern about the IPPS-exempt status of an LTCH that is subject to a payment adjustment for a discharge payment percentage of less than 50 percent, CMS says the hospital will remain an LTCH as long as it maintains an average length of stay of 25 or more days.

CMS finalizes its policies and timelines for determination of the discharge payment percentage (six months after the end of the LTCH's cost reporting period) and the application of the payment adjustment for LTCHs with a discharge payment percentage is less than 50 percent. Where the discharge payment percentage is less than 50 percent, CMS will notify the LTCH that it will be paid for all of its discharges at IPPS comparable amounts for discharges occurring during its next cost reporting period. For example, CMS would calculate the discharge payment percentage for a cost reporting period beginning on January 1, 2020 and ending on December 31, 2020 in July, 2021. If the discharge payment percentage is less than 50 percent, CMS would inform the LTCH it will be paid at IPPS comparable amounts for all of its discharges beginning with its January 1, 2022 cost reporting period and each succeeding cost reporting period (subject to reinstatement). CMS codifies these policies in new §§412.522(d)(3) and 412.522(d)(4).

In the proposed rule, CMS clarified that LTCHs subject to the payment adjustment would receive payment at the IPPS-comparable *per diem* amount (which also used to calculate payments under the SSO policy and site neutral payment rate payments) with an additional payment for high-cost outlier cases that would be based on the IPPS fixed-loss amount in effect at the time of the LTCH discharge. In response to questions, CMS clarifies that the payment adjustment will be the full amount calculated under §412.529(d)(4)(i)(A)—not the per diem amount. CMS revises the final regulation text to refer to the amount paid under the payment adjustment to be an amount equivalent to the IPPS amount (as opposed to what the agency had proposed which was a reference to an amount comparable to the IPPS amount) determined under §§412.529(d)(4)(i)(A), (ii) and (iii), with an additional payment for high cost outlier cases based on the IPPS fixed-loss amount in effect at the time of the LTCH discharge.

CMS also clarifies that the outlier payment under this payment adjustment policy differs from its policy for making LTCH PPS outlier payments for site neutral discharges. The agency notes this is attributable to the language of the statute which states that the payment adjustment shall be the amount that "would apply under subsection (d) for the discharge if the hospital were a subsection (d) hospital."

Finally, CMS confirms that payment adjustments are appealable to the PRRB.

Reinstatement Process

The statute also requires that CMS establish a reinstatement process for the payment adjustment to be discontinued. Under the final policy, an LTCH can be reinstated to receiving payment at the LTCH standard federal payment rate when the discharge payment percentage goes back above 50 percent for a subsequent cost reporting period. Following the above example, if the hospital's discharge payment percentage exceeded 50 percent in its January 1, 2021 toDecember 31, 2021 cost reporting period, the LTCH would be reinstated to receiving payments based on the LTCH standard federal rates and site neutral rates for its January 1, 2023 to December 31, 2023 cost reporting period. CMS codifies the reinstatement process for LTCHs in new §412.522(d)(5).

In response to commenters who requested that the payment adjustment be discontinued at any point when an LTCH demonstrates it meets the discharge payment percentage threshold, CMS notes that the statute calls for application of the policy on the basis of cost reporting periods.

Although CMS believes the reinstatement process would satisfy the statutory requirement without further modification, CMS is concerned that hospitals may be able to manipulate discharges or delay billing in such a way as to artificially inflate their discharge payment percentage if it did not create a special reinstatement process that is probationary. For this reason, CMS provides for a special probationary cure process to recognize that there may be unusual circumstances that result in a discharge payment percentage that may not be fully reflective of an LTCH's typical mix of site neutral and LTCH PPS standard Federal paymentrate discharges (for example, patients require a shorter period of ventilation than was expected on admission). Under this process, there is a probationary cure period of six months. During the cure period, payment based on the IPPS comparable amount will be delayed for six months if for at least 5 consecutive months of the 6-month period immediately preceding the beginning of the cost reporting period during which the adjustment would apply, the discharge payment percentage is at least 50 percent. Under such circumstances, the LTCH is not ultimately subject to the payment adjustment for the cost reporting period during which the adjustment would apply—provided the discharge payment percentage for that cost reporting period is at least 50 percent. If the discharge payment percentage for that cost reporting period is not at least 50 percent, the adjustment will be applied to the cost reporting period at settlement.

Following the above example, an LTCH would be informed of a discharge payment percentage of less than 50 percent for its calendar year 2020 cost reporting period in July of 2021. The probationary cure period would be July 1, 2021 through December 31, 2021. If the LTCH maintained a discharge payment percentage of 50 percent for 5 consecutive months between July 1, 2021 and December 31, 2021, application of the payment adjustment will be delayed for its 2022 cost reporting period. However, if the discharge payment percentage for the 2022 cost reporting period is not at least 50 percent, the payment adjustment delay will be lifted, and the 2022 cost report settlement will be made using an IPPS-comparable amount for all discharges.

While CMS acknowledges that the special probationary cure process is not required by statute, it believes that use of the probationary cure period is the best way to balance administrative simplicity while allowing for unusual circumstances. CMS also recognizes that the special probationary cure process requires additional time between when discharges may be subject to the payment adjustment and when a final determination is made to apply the adjustment. CMS notes that the timing of the final settlement of the cost report is unaffected. However, the agency may reexamine the need for this process taking into account the burden it imposes on LTCHs.

CMS codifies the special probationary reinstatement process at §412.522(d)(6).

D. LTCH PPS Payment Rates and Other Changes

Overview LTCH PPS Payment Rate Adjustments

Only LTCH discharges meeting the site neutral payment rate exclusion criteria are paid based upon the LTCH PPS standard federal payment rate. The LTCH PPS uses a single payment rate to cover both operating and capital-related costs, so that the LTCH market basket includes both operating and capital cost categories.

As in FY 2019, site neutral payment rate cases will be paid in FY 2020 at a rate that is based on the lower of the IPPS comparable *per diem* amount or 100 percent of the estimated cost of the cases.

Update for LTCHs

Using IGI's second quarter 2019 forecast, CMS calculates an annual update to the LTCH PPS standard federal payment rate of 2.5 percent. The update is equal to the 2013-based LTCH market basket of 2.9 percent less 0.4 percentage points for multifactor productivity. For LTCHs failing to submit data to the LTCH Quality Reporting Program (QRP), the annual update is further reduced by 2.0 percentage points. The LTCH update for FY 2020 is:

Factor	Full Update	Reduced Update for Not Submitting Quality Data
LTCH Market Basket	2.9%	2.9%
Multifactor Productivity	-0.4	-0.4
Quality Data Adjustment	0.0	-2.0
Total	2.5%	0.50%

Area Wage Levels and Wage-Index

CMS finalizes a labor-related share of 66.3 percent for FY 2020 based on IGI's second quarter 2019 forecast of the 2013-based LTCH market basket. This is based on the sum of the labor-related portion of operating costs (62.2%) and capital costs (4.1%). Operating costs include the following cost categories: wages and salaries; employee benefits; professional fees; labor-related; administrative and facilities support services; installation, maintenance, and repair services; and all other labor-related services.

CMS computes the wage index as it has done with prior years. After publication of the proposed rule, CMS identified an error in the proposed rule wage index values. CMS explains that a programming error caused the data for all providers in a single county to be included twice, which affected the national average hourly rate, and therefore affected all wage index values. In the final rule, CMS changed the programming logic so this error cannot occur again. In addition, it corrected the classification of one county in North Carolina to rural status, as this county was erroneously identified as being in an urban CBSA.

Using the same methodology as in prior years, CMS calculates an area wage level budget neutrality factor of 1.0020203.

LTCH Standard Federal Payment Rate Calculation

CMS determines the following LTCH PPS standard federal payment rates for FY 2020; CMS notes that the calculations are performed on rounded numbers:

FY 2020 payment rate = $41,558.68 (FY 2019 payment rate) * 1.025 (statutory update factor) * 1.0020203 (area wage budget neutrality factor) * 0.999858 (25% threshold budget neutrality factor) = $42,677.63

For LTCHs not reporting data to the LTCH QRP: FY 2020 payment rate = $41,558.68 (FY 2019 payment rate) * 1.005 (statutory update factor less quality adjustment) * 1.0020203 (area wage budget neutrality factor) * 0.999858 (25% threshold budget neutrality factor) = $41,844.89

Elimination of the 25 Percent Rule

In the FY 2019 IPPS rule, CMS adopted a policy to eliminate the 25 percent rule. The 25 percent rule would have paid LTCHs at an IPPS comparable amount for all discharges not meeting the criteria to be paid the LTCH standard rate above 25 percent of the LTCH's total discharges. CMS adopted a policy to make elimination of this policy budget neutral throughtwo temporary one-time adjustments to the LTCH standardized amount: 0.990878 for FY 2019 and 0.990737 for FY 2020 and permanent one-time adjustment to the LTCH standardized amount of 0.991249 in FY 2021. A one-time temporary adjustment means the adjustment is removed for the following year while a one-time permanent adjustment stays on the rate and is not removed. For FY 2020, the net of removing the 0.990878 adjustment and adding the 0.990371 adjustment is 0.999858.

Cost-of-Living (COLA) Adjustment

CMS updates the COLA factors for Alaska and Hawaii as it has done since FY 2014. To account for higher living costs in Alaska and Hawaii, a COLA is provided to LTCHs in those states. The COLA is determined by comparing Consumer Price Index growth in Anchorage, Alaska and

Honolulu, Hawaii to that of the average U.S. city. The COLA is capped at 25-percent and updated every 4 years. Shown below are the FY 2020 COLAs.

Cost-of-Living Adjustment Factors for Alaska and Hawaii Under the LTCH PPS for FY 2020	
Alaska	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.25
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.25
City of Juneau and 80-kilometer (50-mile) radius by road	1.25
All other areas of Alaska	1.25
Hawaii	
City and County of Honolulu	1.25
County of Hawaii	1.21
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

High-Cost Outlier (HCO) Case Payments

Section 1886(m)(7)(A) of the Act requires CMS to reduce the LTCH standard federal payment rate by 8 percent for HCOs. Section 1886(m)(7)(B) requires the agency to set the outlier threshold such that estimated outlier payments equal 99.6875 percent of the 8 percent estimated aggregate payments for standard federal payment rate cases (that is, 7.975 percent). Consistent with the statute and using the most recent available data, CMS determines an HCO fixed-loss amount of $26,778 which CMS estimates will result in 7.975 of LTCH standard federal payment rate cases being paid as HCOs. The HCO payment continues to equal 80 percent of theestimated care cost and the outlier threshold (adjusted standard rate payment plus fixed-loss amount). If an HCO case is also an SSO case, the HCO payment will equal 80 percent of the estimated case cost and the outlier threshold (SSO payment plus fixed-loss amount).

The final fixed-loss amount of $26,778 for FY 2020 for LTCH PPS standard Federal payment rate cases is significantly lower than the proposed fixed-loss amount of $29,997. CMS notes it used the most recent data for the final rule (LTCH claims data from the March 2019 update of the FY 2018 MedPAR file and CCRs from the March 2019 update of the PSF).

Consistent with its practice since FY 2016, CMS continues to believe that the most appropriate fixed-loss amount for site neutral payment rate cases is the IPPS fixed-loss amount. For FY 2020, CMS establishes $26,473 as the fixed-loss amount for site neutral payment rate cases.

CMS finalizes a budget neutrality factor of 0.949 for site neutral payment rate cases for FY 2020. Consistent with the policy adopted in FY 2019, CMS does not apply the HCO budget neutrality adjustment to the HCO portion of the site neutral payment rate amount. CMS estimates that HCO payments for site neutral payment rate cases would be 5.1 percent of the site neutral payment rate payments.

IPPS DSH and Uncompensated Care Payment Adjustment Methodology

CMS continues its policy that the calculations of the “IPPS comparable amount” (42 CFR §412.529) and the “IPPS equivalent amount” (§412.534 and §412.536) include an applicable operating Medicare DSH and uncompensated care payment amount. For FY 2020, the

DSH/uncompensated care amount equals 75.36 percent of the operating Medicare DSH payment amount, based on the statutory Medicare DSH payment formula prior to the amendments made by the ACA adjusted to account for reduced payments for uncompensated care resulting from expansion of the insured population under the ACA.

E. Impact of Payment Rate and Policy Changes to LTCH PPS Payments

CMS Impact Analysis for LTCHs

CMS projects that the overall impact of the payment rate and policy changes, for all LTCHs from FY 2019 to FY 2020, will result in an increase of 1.0 percent or $43 million in aggregate payments (from $4.271 billion to $4.314 billion). This estimated increase in payments reflects the projected increase in payments to LTCH PPS standard federal payment rate cases of approximately 2.7 percent ($91 million) and the projected decrease in payments to site neutral payment rate cases of approximately 5.9 percent (-$49 million estimated). CMS modeling assumes that approximately 71 percent of LTCH cases will meet the criteria for exclusion from the site neutral payment rate (that is, those cases will be paid the LTCH PPS standard federal payment rate) and approximately 29 percent of LTCH cases will be paid the site neutral payment rate (calculated using FY 2018 LTCH claims data).

CMS was unable to model the impact of LTCH PPS payment changes for site neutral payment rate cases as it did for standard federal payment rate cases. Thus, Table IV "Impact of Payment Rate and Policy Changes to LTCH PPS Payments for LTCH PPS Standard Federal Payment Rate Cases for FY 2020" in the final rule shows the detailed impact by location, participation date, ownership type, region, and bed size for only LTCH PPS standard federal payment rate cases and does not include the detailed impact in payments for site neutral payment rate cases. CMS reports that regional differences in impacts are largely due to updates to the wage index.

The impacts below do not account for the potential that an LTCH's discharge payment percentage will not meet the 50 percent threshold and it will be paid at an IPPS comparable amount in a subsequent cost reporting period. As this policy will not affect any LTCHs until FY 2022, the policy will not have any impact in FY 2020. CMS estimates the policy will reduce Medicare spending under the LTCH PPS by $50 million in FY 2022.

Summary of Impact of Changes to LTCH PPS Standard Federal Payment Rate Cases for FY 2020		
	Number of LTCHs	**Estimated Percent Change in payments per discharge**
All LTCH providers	384	2.3%
By Location:		
Rural	19	2.2%
Urban	365	2.3%
By Ownership Type:		
Voluntary	75	2.5%
Proprietary	295	2.3%
Government	14	2.5%
By Region		
New England	10	2.2%
Middle Atlantic	25	2.2%

	Number of LTCHs	Estimated Percent Change in payments per discharge
South Atlantic	63	2.5%
East North Central	25	2.4%
East South Central	64	2.2%
West North Central	32	2.3%
West South Central	111	2.3%
Mountain	30	2.2%
Pacific	24	2.3%
*More detail is available in Table IV "Impact of Payment Rate and Policy Changes to LTCH PPS Payments for LTCH PPS Standard Federal Payment Rate Cases for FY 2020" on pages 2232-2233 of the display copy.		

Tables. The complete set of tables providing detail on the LTCH PPS for FY 2020 is accessible at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/LTCHPPS- Regulations-and-Notices-Items/LTCH-PPS-CMS-1716-F.html?DLPage=1&DLEntries=10&DLSort=3&DLSortDir=descending

F. Long-Term Care Hospital Quality Reporting Program (LTCH QRP)

The LTCH QRP was first implemented in FY 2014, as required under section 1886(m) of the Act. Further developed in subsequent rulemaking, the LTCH QRP follows many of the policies established for the IQR Program, including the principles for selecting measures and the procedures for hospital participation in the program. An LTCH must meet LTCH QRP patient assessment and quality data reporting requirements or be subject to a 2.0 percentage point update factor reduction. LTCHs submit data on the LTCH Continuity Assessment Record and Evaluation Data Set (LTCH CARE Data Set or LCDS) patient assessment instrument to CMS using the Quality Improvement Evaluation System Assessment Submission and Processing (QIES ASAP) system.

A table at the end of this section (item VIII.C.7) displays the measures previously adopted for the LTCH QRP for FYs 2019 through 2021 and the newly finalized measures for FY 2022.

1. New Measures and Measure Update for FY 2022

CMS finalizes the addition of two new process measures for the LTCH QRP beginning with FY 2022 for a new quality measure domain entitled "Transfer of Health Information." In addition, CMS updates the specifications for the Discharge to Community PAC LTCH QRP measure in order to exclude baseline nursing facility (NF) residents from the measure. Specifications for these measures are available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/Final-Specifications-for-LTCH-QRP-Quality-Measures-and-SPADEs.pdf. Data submission requirements for the two new measures are discussed in VIII.C.4 below.

- Transfer of Health Information to the Provider -- PAC Measure. This measure assesses whether a current reconciled medication list is given to the subsequent provider when an individual transitions from a post-acute care (PAC) setting to another setting. Specifically, it is calculated as the proportion of patient stays with a discharge assessment indicating that a current reconciled medication list was provided to the subsequent provider at discharge. The denominator is the total number of LTCH patient stays ending in discharge to a subsequent

provider (an acute care hospital, intermediate care, home under the care of a home health service organization or hospice, institutional hospice, skilled nursing facility (SNF), another LTCH, inpatient rehabilitation facility (IRF), inpatient psychiatric facility, or a CAH). The numerator is the number of LTCH patient stays with an LCDS discharge assessment indicating a current reconciled medication list was provided to the subsequent provider at discharge.

- Transfer of Health Information to the Patient -- PAC Measure. This related new measure assesses whether a current reconciled medication list was provided to the patient, family, or caregiver when a patient was discharged from a PAC setting to a private home/apartment, board or care home, assisted living, group home, transitional living, or home under care of a home health service organization or hospice. The measure denominator is the total number of LTCH patient stays ending in discharge to the locations listed above, and the numerator is the number of LTCH patient stays with an LCDS discharge assessment indicating that a current reconciled medication list was provided to the patient, family, or caregiver at discharge.
- Update to the Discharge to Community PAC Measure. The specifications for this measure are updated to remove baseline nursing facility residents beginning with the FY 2020 LTCH QRP. The measure reports an LTCH's risk-standardized rate of Medicare fee-for-service patients who are discharged to the community following an LTCH stay, who within the following 31 days remain alive and do not have an unplanned readmission to an acute care hospital or LTCH. Baseline NF residents are defined as LTCH patients who had a long-term NF stay in the 180 days preceding their hospitalization and LTCH stay, with no intervening community discharge between the NF stay and qualifying hospitalization.

CMS responds to a number of comments regarding the transfer of information measures. It states that it plans to submit them for NQF endorsement as soon as feasible. CMS believes these measures will not substantially increase burden on LTCHs because many hospitals already generate medication lists as a best practice for discharge planning. Further, CMS rejects a suggestion that the "not applicable" answer choice available in the home health version of this measure be applied to all PAC settings, including LTCHs. It says that this option is available because, unlike facility settings, a home health agency may not be immediately aware of a patient's status, for example, when a patient is taken to the emergency room.

Regarding exclusion of baseline nursing facility residents from the discharge to community measure, CMS reports that all commenters except MedPAC supported this change. CMS disagrees with MedPAC and says that community is generally understood by policy makers, providers and other stakeholders to mean non-institutional settings, and that baseline nursing facility residents are an inherently different patient population.

2. Request for Information on LTCH QRP Quality Measures, Measure Concepts and Standardized Patient Assessment Data Elements under Consideration for Future Years

In the proposed rule CMS sought comment on the importance, relevance, appropriateness and applicability of the following measures, Standardized Patient Assessment Data Elements (SPADEs) and concepts under consideration for future years. CMS describes but does not respond to the comments it received, which will be considered in future policy making.

- Quality Measures and Measure Concepts
    - Functional mobility outcomes
    - Sepsis
    - Opioid use and frequency
    - Exchange of electronic health information and interoperability
    - Nutritional status
- Standardized Patient Assessment Data Elements
    - Cognitive complexity, such as executive function and memory
    - Dementia
    - Bladder and bowel continence including appliance use and episodes of incontinence
    - Care preferences, advance care directives, and goals of care
    - Caregiver Status
    - Veteran Status
    - Health disparities and risk factors, including education, sex and gender identity, and sexual orientation

3. Standardized Patient Assessment Data Reporting Beginning with FY 2022

The IMPACT Act requires that, beginning in FY 2019, LTCHs must report SPADEs as required for at least the quality measures with respect to certain categories, summarized here as functional status; cognitive function; special services and interventions; medical conditions and comorbidities; impairments; and other categories deemed necessary and appropriate by the Secretary. The standardized patient assessment data must be reported under the LTCH QRP at least with respect to LTCH admissions and discharges, but the Secretary may require the data to be reported more frequently.

In this rule, CMS finalizes requirements that LTCHs report a new series of SPADEs. The list of newly adopted SPADEs, along with information on their current use in PAC patient assessment instruments and whether changes apply to the LCDS are summarized in a table below. Detailed specifications for the SPADEs are available https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/Final-Specifications-for-LTCH-QRP-Quality-Measures-and-SPADEs.pdf. A final change table and mockup of LTCH QRP items are available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-Downloads-and-Videos.html. These latter two documents also include the data elements associated with the new transfer of health information measures discussed above. (Note that unlike for all the other SPADEs, the preamble omits the specific declaration of adoption of the health literacy SPADEs, but its adoption is implied elsewhere in the discussion.)

The required reporting will begin with the FY 2022 LTCH QRP. For FY 2022 the data will be reported with respect to both admissions and discharges occurring between October 1, 2020 and December 31, 2020. For FY 2023 and later years, the data will be required for admissions and discharges that occur during a calendar year – 2021 for the FY 2023 LTCH QRP, 2022 for the FY 2024 LTCH QRP, etc.

For each SPADE, the final rule discusses the rationale, whether the element is currently used in any PAC patient assessment instruments, describes past comments from stakeholders and pilot testing and responds to comments on the proposed rule. Most of the newly adopted SPADEs were proposed but not finalized as part of FY 2018 rulemaking. Those that were newly discussed in this year's rulemaking involve functional status (six mobility-related data elements already adopted for the other three PAC settings); high risk drug classes; pain interference; and social determinants of health, which is a newly added category of SPADEs. These address race, ethnicity, preferred language and interpreter services, health literacy, transportation, and social isolation.

With a change from the proposed rule, CMS finalizes that if certain SPADEs are submitted with respect to admission only, they will be deemed to have been submitted for both admission and discharge as generally required. This policy is finalized because assessment of certain elements is unlikely to change between admission and discharge. As proposed, this policy is finalized for the Hearing, Vision, and Race and Ethnicity SPADEs. In addition, based on comments received from stakeholders, CMS will also apply this policy to the new SPADEs regarding preferred language and interpreter services. CMS disagrees with comments suggesting the policy also apply to other SPADEs, including social isolation and health literacy.

Responding to commenters concerned with low frequency of a number of the SPADEs, CMS states that tracking important clinical information has value in care planning and transfer of information, even when events are rare. CMS also responds to numerous specific comments on individual SPADEs. Regarding its plans for using SPADEs, CMS reiterates its intention to use SPADE data to inform care planning, the common standards and definitions to facilitate interoperability, and for developing standardized measures. It intends to continue to collaborate with stakeholders during the policy development process and through future rulemaking.

In the collection of information requirements section of the final rule CMS estimates that the changes to the LTCH QRP (i.e., data collection for the new transfer of information measures and the SPADEs) will require additional data collection efforts and annual costs will total about $5,675 per LTCH or $2.35 million across all LTCHs.

New Standardized Patient Assessment Data Elements, by Category		
Data Elements	**Current Use/Test of Elements***	**Change to LCDS**
Functional Status		
Mobility Data Elements: Car Transfer; Walking 10 feet on uneven surfaces; 1 step (curb); 4 steps; 12 steps; Picking up object	MDS IRF-PAI OASIS	New item
Cognitive Function and Mental Status		
Brief Interview for Mental Status (BIMS)	MDS IRF-PAI	New item
Confusion Assessment Method	LCDS (6 items) MDS (4 items)	Replace LCDS item
Patient Health Questionnaire-2 to 9 (depression screening)	MDS (PHQ-9) OASIS (PHQ-2)	New item

New Standardized Patient Assessment Data Elements, by Category		
Data Elements	**Current Use/Test of Elements***	**Change to LCDS**
Special Services, Treatments, and Interventions		
Cancer Treatment: Chemotherapy (IV, Oral, Other)	MDS (single)	New item
Cancer Treatment: Radiation	MDS	New item
Respiratory Treatment: Oxygen Therapy (Intermittent, Continuous, High-concentration Oxygen Delivery)	MDS OASIS PAC PRD	New item
Respiratory Treatment: Suctioning (Scheduled, As needed)	MDS PAC PRD	New item
Respiratory Treatment: Tracheostomy Care	MDS	New item
Respiratory Treatment: Non-invasive Mechanical Ventilator (BiPAP, CPAP)	LCDS MDS	Replace LCDS item
Respiratory Treatment: Invasive Mechanical Ventilator	LCDS MDS	Replace LCDS item
Intravenous (IV) Medications (Antibiotics, Anticoagulation, Vasoactive Medications, Other)	LCDS MDS OASIS	Replace LCDS items
Transfusions	MDS PAC PRD	New item
Dialysis (Hemodialysis, Peritoneal dialysis)	LCDS MDS	Replace LCDS item
Other Treatment: Intravenous (IV) Access (Peripheral IV, Midline, Central line, Other)		New item
Nutritional Approach: Parenteral/IV Feeding	LCDS MDS IRF-PAI OASIS	Replace LCDS item
Nutritional Approach: Feeding Tube	MDS OASIS IRF-PAI PAC PRD	New item
Nutritional Approach: Mechanically Altered Diet	MDS OASIS IRF-PAI	New item
Nutritional Approach: Therapeutic Diet	MDS	New item
High-Risk Drug Classes: Use and Indications		New item
Medical Condition and Comorbidity Data		
Pain Interference (Pain Effect on Sleep, Pain Interference with Therapy Activities, and Pain Interference with Day-to-Day Activities)	OASIS MDS	New item
Impairment		
Hearing	MDS	New item **
Vision	MDS OASIS	New item **
Social Determinants of Health		
Race	MDS LCDS IRF-PAI OASIS	Modify LCDS items**
Ethnicity		
Preferred Language and Interpreter Services	MDS	Modify LCDS item**

New Standardized Patient Assessment Data Elements, by Category		
Data Elements	**Current Use/Test of Elements***	**Change to LCDS**
	LCDS	
Health Literacy		New item
Transportation	PREPARE/AHC screening tool	New item
Social Isolation	PROMISE/AHC screening tool	New item
*This column reflects whether the specific elements, or similar or related elements, are included in the current PAC assessment instruments or tested in the PAC PRD. The PAC instruments referenced are: LCDS; SNF Minimum Data Set (MDS); Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI); Long-Term Care Hospital Continuity Assessment Record and Evaluation Data Set (LCDS); and OASIS for home health agencies. ** LTCHs submitting these SPADEs with respect to admission only will be deemed to have submitted them for both admission and discharge, because it is unlikely that assessment of these SPADEs would change during the LTCH stay.		

4. Form, Manner, and Timing of Data Submission

Reporting System Update

CMS reports that it is upgrading the Quality Improvement and Evaluation System (QIES) Assessment and Submission Processing (ASAP) system used by LTCHs to report LTCH QRP data to CMS. The new system will be called the internet QIES (iQIES) and makes changes to the regulatory text consistent with this change effective October 1, 2019. A general reference to use of a "CMS-designated data submission system" will replace the existing references to QIES ASAP.

Schedule for Reporting Requirement Updates

The implementation date of any new version of the LCDS is moved from April to October, beginning October 1, 2020. This aligns the LCDS with the MDS and IRF-PAI implementation dates and provide LTCHs an additional 6 months to prepare for any changes to the reporting requirements. In addition, for the first program year in which measures or SPADEs are adopted, LTCHs will only be required to report data on patients who are admitted and discharged during the last quarter (October 1 to December 31) of the calendar year that applies to the program year. Full calendar year reporting will apply in subsequent years. For new data elements to be reported in 2020 for the FY 2022 payment determination, the reporting deadline for the fourth quarter 2020 data will be May 15, 2021. The final rule includes tables displaying the reporting deadlines for the FY 2022 and FY 2023 payment determinations.

Schedule for Reporting Transfer of Health Information Quality Measures and SPADES

As summarized in section VIII.C.1 above, two new measures are adopted beginning with FY 2022 payment. LTCHs must collect data for these measures beginning with patients discharged on or after October 1, 2020. The initial reporting schedule described above applies.

Similarly, with respect to reporting on the new SPADEs as summarized in section VIII.C above, LTCHs must collect data for all patients discharged on or after October 1, 2020 at both admission and discharge. As noted above, for certain SPADEs, collection by an LTCH at admission only is deemed to meet this requirement. The initial reporting schedule described above will apply.

5. Removal of the List of Compliant LTCHs

CMS will stop publishing a list of compliant LTCHs, (i.e., those meeting the LTCH QRP reporting requirements) on the LTCH QRP website, effective beginning with the FY 2020 payment determination. CMS agrees with feedback it has received from stakeholders that this listing does not provide new information to providers regarding their annual payment update status.

6. Public Display of Measure Data for the LTCH QRP

The LTCH QRP measure "Drug Regimen Review Conducted with Follow-Up for Identified Issues" will be added for public display to the *Long Term Care Hospital Compare* website at https://www.medicare.gov/longtermcarehospitalcompare/.

Display will begin with 2020 or as soon as technically feasible. The data display will be for a rolling four quarters of data, initially using data for discharges occurring during calendar year 2019. Data for LTCHs with fewer than 20 eligible cases in any four consecutive rolling quarters will not be publicly displayed. For those LTCHs, the website will indicate that the number of cases is too small to publicly report.

7. Table of LTCH QRP Measures

LTCH QRP Measures, by Year				
Measure Title	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
NHSN Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138)	X	X	X	X
NHSN Central line-associated Blood Stream Infection (CLABSI) Outcome Measure (NQF #0139)	X	X	X	X
Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short-Stay) (NQF #0678)	X	Replaced		
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury		X	X	X
Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680)	X	X	Removed	
Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431)	X	X	X	X
NHSN Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716)	X	X	Removed	

LTCH QRP Measures, by Year				
Measure Title	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
NHSN Facility-Wide Inpatient Hospital-onset Clostridium Difficile Infection (CDI) Outcome Measure (NQF #1717)	X	X	X	X
All-Cause Unplanned Readmissions for 30 Days Post Discharge from LTCHs (NQF #2512)	Removed			
Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (Application of NQF #0674)	X	X	X	X
Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)	X	X	X	X
Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631)	X	X	X	X
Change in Mobility among Long-Term Care Hospital Patients Requiring Ventilator Support (NQF #2632)	X	X	X	X
NHSN Ventilator Associated Event Outcome Measure	X	X	Removed	
Medicare spending per beneficiary MSPB-PAC LTCH	X	X	X	X
Discharge to Community PAC LTCH*	X	X	X	X
Potentially Preventable Readmissions 30 Days Post LTCH Discharge	X	X	X	X
Drug Regimen Review Conducted with Follow-up		X	X	X
Mechanical Ventilation Process Measure: Compliance with Spontaneous Breathing Test by Day 2 of the LTCH Stay		X	X	X
Mechanical Ventilation Outcome Measure: Ventilator Liberation Rate		X	X	X
Transfer of Health Information to the Provider – PAC Measure				X
Transfer of Health Information to the Patient – PAC Measure				X
* Measure updated to remove baseline nursing facility patients beginning in FY 2020.				