PROPOSED RULE
Federal Fiscal Year 2021 Medicare Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) Proposed Rule
SUMMARY

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VII. 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 2021:

- 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 hospital that 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 ventilator criterion).

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

CMS proposes 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. The FY 2019 IPPS final rule made conforming changes to the regulations to implement the extended transitional blended payment.

Summary of Proposed Changes to LTCH PPS Rates for FY 2021*	
Standard Federal Rate, FY 2020	$42,677.64
Proposed Rule Update factors	
Update as required by Section 1886(m)(3)(C) of the Act (including MFP reduction)	+2.5%
Penalty for hospitals not reporting quality data (including MFP reduction)	-2.0%
Net update, LTCHs reporting quality data	+2.5% (1.025)
Net update LTCHs not reporting quality data	0.5% (1.005)
Proposed Rule Adjustments	
Proposed average wage index budget neutrality adjustment	1.0018755
Proposed permanent budget neutrality adjustment factor of 0.991249 for the cost of the elimination of the 25-percent threshold policy for FY 2021 (and subsequent years); removal of FY 2020 adjustment factor of 0.990737	1.000517
Proposed Standard Federal Rate, FY 2021	
LTCHs reporting quality data ($42,677.64*1.025*1.0018755*1.000517)	$43,849.28
LTCHs not reporting quality data ($42,677.64*1.005*1.0018755*1.000517)	$42,993.68

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Summary of Proposed Changes to LTCH PPS Rates for FY 2021*	
Proposed Fixed-loss Amount for High-Cost Outlier (HCO) Cases	
LTCH PPS standard federal payment rate cases	$30,515
Site neutral payment rate cases (same as the IPPS fixed-loss amount)	$30,006
Impact of Proposed Policy Changes on LTCH Payments in 2021	
Total estimated impact	-0.9% (-$36 million)
LTCH standard federal payment rate cases (75% of LTCH cases)	+2.1% (+$69 million)
Site neutral payment rate cases (25% of LTCH cases)**	-21% (-$105 million)
*More detail is available in Table IV, "Impact of Proposed Payment Rate and Policy Changes to LTCH PPS Payments for Standard Payment Rate Cases for FY 2021". 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

1. Background

Similar to FY 2020, the annual recalibration of the MS-LTC-DRG relative weights for FY 2021 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.

2. Patient Classification into MS-LTC-DRGs

CMS proposes to continue 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 also would be incorporated into the MS-LTC-DRG system for FY 2021 since the two systems share an identical base. Proposed MS-DRG changes are described elsewhere in this summary and details can be found in section II.F. of the preamble of the proposed rule.

3. Development of the MS-LTC-DRG Relative Weights

In developing the FY 2021 relative weights, CMS proposes to use 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).

4. Relative Weights Source Data

FY 2021 proposed relative weights are derived from the December 2019 update of the FY 2019 MedPAR file. These data are filtered to identify LTCH cases meeting the established site neutral payment exclusion criteria. The filtered data are trimmed to exclude all-inclusive rate providers, Medicare Advantage claims, and demonstration project participants, yielding the "applicable LTCH data." (CMS notes there were no data from any LTCHs paid under a demonstration project

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in the December 2019 update.) The applicable LTCH data are used with Version 38 of the GROUPER to calculate the FY 2021 MS-LTC-DRG proposed relative weights.

5. Hospital-Specific Relative-Value Methodology (HSRV)

CMS proposes to continue to use its HSRV methodology in FY 2021, unchanged from FY 2020, 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.

6. Volume-related adjustments

CMS proposes to continue 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 finds that there are 252 such MS-LTC-DRGs. CMS then determines a proposed 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. (See http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html for these low-volume MS-LTC-DRGs.)
- If an MS-LTC-DRG has zero cases after data trims are applied (CMS identifies 347 of these MS-LTC-DRGs), it is cross-walked to another proposed MS-LTC-DRG based on clinical similarities in resource use intensity and relative costliness in order to assign an appropriate proposed relative weight. If the MS-LTC-DRG that is similar is a low-volume DRG that has been assigned to one of the five quintiles noted above, then the zero volume MS-LTC-DRG would be assigned to that same quintile. This total excludes the 11 transplant, 2 "error" and 15 psychiatric or rehabilitation MS-LTC-DRGs. (See http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html for these zero-volume MS-LTC-DRGs.)

CMS will assign a 0.0 relative weight for the 11 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 will not calculate a weight for the 15 psychiatric and rehabilitation proposed MS-LTC-DRGs because these MS-LTC-DRGs would never include any LTCH cases meeting the site neutral payment rate exclusion criteria.

7. 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. When relative weights decrease as severity increases in a DRG ("nonmonotonic"), CMS proposes to continue for FY 2021 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.

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

CMS proposes to continue its methodology of calculating 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 proposes to apply its existing two-step methodology to achieve budget neutrality for the FY 2021 MS-LTC-DRG and relative weights update (Step 7). First, a normalization adjustment is applied to the recalculated relative weights to ensure that the recalibration does not change the average case mix index (1.25878 proposed for FY 2021). Second, a budget neutrality factor is applied to each normalized relative weight (0.9993445 proposed for FY 2021).

Extensive discussion of the entire 7-step process to determine MS-LTC-DRG relative weights is provided in the proposed rule (pages 1,017 to 1,034 of the display copy).

C. LTCH PPS Payment Rates and Other Changes

1. 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.

2. Proposed Annual Update for LTCHs

The proposed annual update to the LTCH PPS standard federal payment rate is equal to 2.9 percent. As discussed in section VII.D of the proposed rule (summarized below), CMS proposes to rebase and revise the 2013-based LTCH market basket to reflect a 2017 base year. Thus, CMS proposes an update equal to the 2017-based LTCH market basket of 2.9 percent less 0.4 percentage points (PP) for multifactor productivity. For LTCHs failing to submit data to the LTCH Quality Reporting Program (QRP), the annual update would be further reduced by 2.0 percentage points. CMS notes that the "other adjustment" under section 1886(m)(4)(F) of the Act does not apply for FY 2021. The proposed LTCH update for FY 2021 is:

Factor	Full Update	Reduced Update for Not Submitting Quality Data
LTCH Market Basket	2.9%	2.9%
Multifactor Productivity	-0.4 PP	-0.4 PP
Quality Data Adjustment	0.0	-2.0 PP
Total	2.5%	0.5%

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3. Area Wage Levels and Wage-Index

CMS proposes to adopt the revised labor market area delineations announced in OMB Bulletin No. 18-04 effective for FY 2021 under the LTCH PPS. This proposal is consistent with the changes proposed under the IPPS for FY 2021 as described in section III.A. of this summary. Under the proposal:

- 34 counties (and county equivalents) currently considered part of an urban CBSA would be considered to be located in a rural area;
- 47 counties (and county equivalents) located in rural areas would be considered to be located in urban areas; and
- Some urban counties would shift from one urban CBSA to another urban CBSA or would shift between existing and new CBSAs.

Because some LTCHs would experience decreases in their wage index values under the proposal, CMS proposes to implement a budget neutral transition policy to help mitigate significant negative impacts that LTCHs may experience due to its proposal to adopt the revised OMB delineations. It proposes to apply a 5-percent cap on any decrease in an LTCH's wage index from the LTCH's final wage index from the prior fiscal year; thus, an LTCH's final wage index for FY 2021 would not be less than 95 percent of its final wage index for FY 2020. However, CMS does not propose a cap on the overall increase in an LTCH's wage index.

As noted above, CMS proposes to rebase and revise the 2013-based LTCH market basket to reflect a 2017 base year. CMS proposes an FY 2021 labor-related share of 68.0 percent based on IGI's fourth quarter 2019 forecast of the 2017-based LTCH market basket. This is based on the sum of the labor-related portion of operating costs (63.6%) and capital costs (4.4%). 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 notes that the difference from the FY 2020 labor-related share is attributable to the revision to the base year cost weights, the revision to the starting point of the calculation of base year from 2013 to 2017, and the use of an updated IHS Global Inc. forecast and reflecting an additional year of inflation.

CMS proposes to compute the wage index in a manner that is consistent with prior years, taking into account the proposed revised labor market area delineations announced in OMB Bulletin No. 18-04. It proposes an area wage level budget neutrality adjustment of 1.0018755.

4. Elimination of the 25 percent Rule

In the FY 2019 IPPS rule, CMS adopted a policy to eliminate the 25 percent rule. This 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 through two temporary one-time adjustments to the LTCH standardized amount (0.990878 for FY 2019 and 0.990737 for FY 2020) and one permanent one-time adjustment to the LTCH standardized amount of 0.991249 for FY 2021 and subsequent years. 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.

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For FY 2021, CMS removes the 0.990737 adjustment (calculated by applying a factor of 1/0.990737) and applies the permanent one-time adjustment of 0.991249. The language in the preamble on this issue appears to be incomplete. In section V.A.2. of the Addendum to the proposed rule, CMS calculates an adjustment factor of 1.000517 for FY 2021.

5. Proposed LTCH Standard Federal Payment Rate Calculation

CMS proposes the following LTCH PPS standard federal payment rates for FY 2021:

- $43,849.28 for LTCHs reporting quality data, calculated as follows: $42,677.64 (FY 2020 payment rate) * 1.025 (statutory update factor) * 1.0018755 (area wage budget neutrality factor) * 1.000517 (25% threshold budget neutrality factor) = $43,849.28

- $42,993.68 for LTCHs not reporting data to the LTCH QRP, calculated as follows: $42,677.64 (FY 2020 payment rate) * 1.005 (statutory update factor less quality adjustment) * 1.0018755 (area wage budget neutrality factor) * 1.000517 (25% threshold budget neutrality factor) = $42,993.68

6. Cost-of-Living (COLA) Adjustment

CMS proposes to continue updating 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 2021 COLAs.

Proposed Cost-of-Living Adjustment Factors for Alaska and Hawaii Under the LTCH PPS for FY 2021	
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

7. 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 CMS 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, CMS proposes an HCO threshold of $30,515 for FY 2021 which CMS estimates will result in 7.975 of LTCH standard federal payment rate cases being paid as HCOs. The HCO

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payment continues to equal 80 percent of the estimated 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). Consistent with historical practice, CMS will use the most recent available LTCH claims data and CCR data for the final rule.

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 2021, CMS proposes a fixed-loss amount for site neutral payment rate cases of $30,006. CMS also proposes a budget neutrality factor of 0.949 for site neutral payment rate cases for FY 2021. Consistent with the policy adopted in FY 2019, CMS proposes that the HCO budget neutrality adjustment would not be applied 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.

8. IPPS DSH and Uncompensated Care Payment Adjustment Methodology

CMS proposes to continue 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 2021, the DSH/uncompensated care amount equals 75.90 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.

D. Rebasing the LTCH Market Basket

1. Background

CMS is proposing to rebase and revise the LTCH market basket. The current LTCH market basket is from a 2013 base year. CMS proposes to base the LTCH market basket on data from cost reports beginning in FY 2017. Rebasing and revising the market basket may result in changes in the cost weights and price proxies used to develop the price index value that is used to update the rates for LTCH services.

2. Proposed 2017-Based LTCH Market Basket Cost Categories and Weights

To determine the index, CMS proposes to use only those LTCHs that have a Medicare average length of stay that is within 25 percent of the LTCH's average length of stay for all patients. CMS believes this selection criterion will result in a more accurate reflection of the structure of costs for Medicare covered days. This selection criterion is the same as was used for the FY 2013-based LTCH market basket.

The proposed selection criterion results in exclusion of 9 percent of LTCH providers. Included LTCH providers had an average Medicare length of stay of 25 days; an all patient average length of stay of 27 days, and aggregate Medicare utilization (based on days) of 58 percent. Excluded

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LTCH providers had an average Medicare length of stay of 27 days, average facility length of stay of 70 days, and aggregate Medicare utilization of 15 percent.

The LTCH market basket includes seven categories of costs plus a residual "all other" category. CMS proposes to derive the cost weights the same way for the FY 2017-based LTCH market basket as it did for the FY 2013-based LTCH market basket with the exception of home office/related organization contract labor:

(1) Wages and Salaries. Costs reported on Worksheet A, column 1, lines 30 through 35, 50 through 76 (excluding 52, 61, and 75), 90 through 91, and 93 and the proportion of overhead salaries that are attributed to Medicare allowable costs centers.

(2) Employee Benefits. Costs reported on Worksheet S-3, part II, column 4, lines 17, 18, 20, and 22. Worksheet S-3 is voluntary for LTCHs. Only 20 percent of LTCHs reported these data. However, CMS believes it has a large enough sample to produce a reasonable employee benefits cost weight because it did not change materially after weighting to reflect the characteristics of the universe of LTCHs (type of control (nonprofit, for-profit, and government) and by region).

(3) Contract Labor. Costs reported on Worksheet S–3, part II. Only 44 percent of LTCHs voluntarily reported costs on Worksheet S-3 part II. CMS's analysis indicates there is a large enough sample to produce a reasonable contract labor cost weight.

(4) Pharmaceuticals. Costs reported on Worksheet B, part I, column 0, lines 15 and 73 and then removing a portion of these costs attributable to salaries (adjusted by the ratio of Worksheet A, column 1, lines 15 and 73 divided by the sum of Worksheet A, columns 1 and 2, lines 15 and 73).

(5) Professional Liability Insurance. Premiums, paid losses and self-insurance costs reported on Worksheet S-2, part I, columns 1 through 3, line 118.

(6) Home Office/Related Organization Contract Labor. Costs reported on Worksheet S–3, part II, column 4, lines 14, 1401, 1402, 2550, and 2551 for those LTCH providers reporting total salaries on Worksheet S-3, part II, line 1. For the 2013-based LTCH market basket, CMS used the 2007 Benchmark Input-Output expense data published by the Bureau of Economic Analysis. CMS believes the proposed methodology for the 2017-based LTCH market basket is a technical improvement over the prior methodology because it represents more recent data that is representative compositionally and geographically of LTCHs.

(7) Capital. Worksheet B, part II, column 26, lines 30 through 35, 50 through 76 (excluding 52, 61, and 75), 90 through 91 and 93.

(8) All Other. Reflects all remaining costs that are not captured in the seven cost categories listed.

CMS proposes to exclude those LTCHs with cost weights that are less than or equal to zero for a category as well as those cost weights that are in the top and bottom 5 percent for all cost

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categories except home office/related organization contract labor. For this cost category, CMS proposes to remove the top 1 percent only as not all LTCHs have a home office and the cost weight for this category may appropriately be zero.

Major Cost Categories	2013 Weight	Proposed 2017 Weight
Wages and Salaries	46.6	46.4
Employee Benefits	7.3	6.8
Professional Liability	0.9	0.5
Pharmaceuticals	7.6	6.2
Home Office/Related Organization Contract Labor	N/A	1.9
Capital	9.7	9.9
All Other	27.8	28.3

The above table does not separately show contract labor. As it did for the 2013-based LTCH market basket, CMS is allocating contract labor to wages and salaries and employee benefits based on its share of costs attributable to each of these categories (87 percent wages and salaries and 13 percent to employee benefits).

CMS provides further detail on the data sources used to derive weights within the capital and all other category. The final detailed cost weights including the subcomponents of capital and all other are found in table E4 (beginning on page 1,062 of the display copy).

3. Selection of Proposed Price Proxies

CMS is proposing to use the same price proxies for the FY 2017-based LTCH market basket as it did for the FY 2013-based LTCH market basket with one highly technical change to how CMS proposes to determine the weight for chemicals—a subcomponent of the all other category.

4. Proposed FY 2021 Market Basket Update for LTCHs

CMS is proposing an FY 2017-based LTCH market basket update of 2.9 percent for FY 2021. This figure will be revised in the final rule based on more recent data. If continued, the FY 2013-based LTCH market basket update would have been 3.0 percent. The FY 2013-based LTCH market basket and the FY 2017-based LTCH market basket differed by 0.2 percentage points or less for each year between FYs 2016-2019 and forecast for FY 2020 through FY 2023. The FY 2017-based LTCH market basket averaged 0.1 percentage point lower in this time period than the FY 2013 LTCH market basket.

5. Proposed FY 2021 Labor-Related Share

The labor-related share of the LTCH standard federal rate is adjusted for area differences in costs. The remaining portion of the LTCH standard federal rate is a uniform national amount. The labor-related share is determined by identifying the national average proportion of total costs that are related to, influenced by, or vary with the local labor market.

CMS proposes to use the same labor-related categories of costs for the FY 2017-based LTCH market basket as it did for the FY 2013-based LTCH market basket: wages and salaries;

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employee benefits; professional fees: labor-related services; administrative and facilities support services; installation, maintenance, and repair services; all other: labor-related services; and a portion of the capital-related costs from the 2017-based LTCH market basket. Professional fees: labor-related services include a proportion of the home office/related organization contract labor costs.

The proposed labor-related share is 68.0 percent compared to 66.3 percent based on the 2013-based LTCH market basket. The different contribution of each cost weight category to the overall difference is shown in the table below:

Major Cost Categories	2013-Based LTCH MB	2017-Based LTCH MB
Wages and Salaries	46.6	46.9
Employee Benefits	7.2	6.8
Professional Fee: Labor-Related	3.4	4.5
Administrative and Facilities Support Services	0.9	1.0
Installation, Maintenance, and Repair Services	2.1	2.1
All Other: Labor-Related Services	2.0	2.3
Subtotal	62.2	63.6
Labor-Related Portion of Capital (46%)	4.1	4.4
Total Labor-Related Share	66.3	68.0

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 2020 to FY 2021, will result in a decrease of 0.9 percent or $36 million in aggregate payments from $3.797 billion to $3.761 billion for the 360 LTCHs included in this impact analysis. This impact results from a decrease in payment to site neutral cases of $105 million and an increase in payment to LTCH standard federal payment rate cases of $69 million.

CMS indicates that there will no longer be any transitional payment for site-neutral cases in FY 2021 like there was in FY 2020 based on the start date of the LTCH's cost reporting period. The lack of a transitional payment will result in a reduction in payment estimated at 21 percent or approximately $105 million for the 25 percent of cases that are estimated to be paid at a site neutral rate.

For the approximately 75 percent of cases estimated to be paid at the standard federal rate, payment is estimated to increase 2.1 percent or approximately $69 million. This increase is primarily due to the proposed 2.5 percent annual update to LTCH standard federal rate for FY 2021 and a 0.5 percent decrease in the proportion of FY 2021 LTCH payments attributed to high cost outliers.

CMS estimates that high cost outliers in FY 2020 will be about 8.5 percent of estimated total LTCH PPS standard federal payment rate payments. As it does annually, CMS proposes to set the high cost outlier threshold for LTCH standard federal payment rate cases so that 8 percent of total payment are made as high cost outliers. The difference between the 8.5 percent figure for FY 2020 and the estimate of 8.0 percent for FY 2021 accounts for the 0.5 percent reduction in payment for high cost outliers.

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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 2021" in the proposed 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.

Summary of Impact of Changes to LTCH PPS Standard Federal Payment Rate Cases for FY 2021		
	Number of LTCHs	**Estimated Percent Change in Payments per Discharge**
All LTCH providers	360	2.1%
By Location:		
Rural	17	1.8%
Urban	343	2.1%
By Ownership Type:		
Voluntary	60	2.1%
Proprietary	290	2.1%
Government	10	2.9%
By Region		
New England	10	1.8%
Middle Atlantic	23	1.9%
South Atlantic	62	2.0%
East North Central	55	2.0%
East South Central	31	1.8%
West North Central	22	1.7%
West South Central	105	2.2%
Mountain	29	2.0%
Pacific	23	2.7%
*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 2021" on pages 1568-1569 of the display copy.		

Tables. The complete set of tables providing detail on the LTCH PPS for FY 2021 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

C. 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

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(LTCH CARE Data Set or LCDS) patient assessment instrument to CMS using the Quality Improvement Evaluation System Assessment Submission and Processing (QIES ASAP) system.

No changes are proposed to the LTCH QRP in this rule. The table below displays the measures previously adopted for the LTCH QRP for FYs 2020 through 2022.

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	
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			
Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (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.				

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