Fiscal Year 2020 Long-Term Care Hospital Prospective Payment System Proposed 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 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 proposed rule made conforming changes to the regulations to implement the extended transitional blended payment.

Summary of Proposed Changes to LTCH PPS Rates for FY 2020*	
Standard Federal Rate, FY 2020	$41,558.68
Proposed Rule Update factors	
Update as required by Section 1886(m)(3)(C) of the Act	+2.7%
Penalty for hospitals not reporting quality data	-2.0%
Net update, LTCHs reporting quality data	+2.7% (1.027)
Net update LTCHs not reporting quality data	0.7% (1.007)
Proposed Rule Adjustments	
Proposed average wage index budget neutrality adjustment	1.0064747
Proposed budget neutrality adjustment to eliminate the 25-percent threshold policy	0.999856
Proposed Standard Federal Rate, FY 2020	
LTCHs reporting quality data ($41,558.68∗1.027∗1.0064747*0.999856)	$42,950.91
LTCHs not reporting quality data ($41,558.68*1.007*1.0064747*0.999856)	$42,114.47
Proposed Fixed-loss Amount for High-Cost Outlier (HCO) Cases	
LTCH PPS standard federal payment rate cases	$29,997

Summary of Proposed Changes to LTCH PPS Rates for FY 2020*	
Site neutral payment rate cases (same as the IPPS fixed-loss amount)	$26,994
Impact of Proposed Policy Changes on LTCH Payments in 2020	
Total estimated impact	0.9% ($37 million)
LTCH standard federal payment rate cases (71% of LTCH cases)	+2.3% (+$79 million)
Site neutral payment rate cases (29% of LTCH cases)**	-4.9% (-$41 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 2020" (see page 1,784 in 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 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 2020 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.

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

In developing the FY 2020 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).

Relative Weights Source Data

FY 2020 proposed relative weights are derived from the December 2018 update of the FY 2018 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." The applicable LTCH data are used with Version 37 of the GROUPER to calculate the FY 2020 MS-LTC-DRG proposed relative weights.

Hospital-Specific Relative-Value Methodology (HSRV)

CMS proposes to continue 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 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. (In the proposed rule, CMS indicated there are 182 such MS-LTC-DRGs.)
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 259 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 Table 13A at the Table link provided below for these low-volume MS-LTC-DRGs.)
If an MS-LTC-DRG has zero cases after data trims are applied (CMS finds that there are 320 such 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 8 transplant, 2 "error" and 15 psychiatric or rehabilitation MS-LTC-DRGs. (See Table 13B at the table link provided below for these zero-volume MS-LTC-DRGs.)

CMS will assign 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 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. To determine a transitional payment for FY 2020, CMS is using 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. When relative weights decrease as severity increases in a DRG ("nonmonotonic"), CMS proposes to continue 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.

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

CMS is continuing 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 is applying its existing two-step methodology to achieve budget neutrality for the FY 2020 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 (1.271 proposed for FY 2020). Second, a budget neutrality factor is applied to each normalized relative weight (0.9971599 proposed for FY 2020).

Extensive discussion of the entire 7-step process to determine MS-LTC-DRG relative weights is provided in the proposed rule (pages 1,076 to 1,094 of the display copy).

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

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 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.

CMS implemented this 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 the FY 2020 IPPS proposed 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 would determine the discharge payment percentage six months after the end of the LTCH's cost reporting period. If the discharge payment percentage is less than 50 percent, CMS would notify the LTCH it will be paid for all of its discharges at IPPS comparable amounts in 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. CMS proposes to codify implementation of this policy in new § 412.522(d)(3).

The statute also requires that CMS establish a reinstatement process. CMS proposes that an LTCH can be reinstated to receiving payment at the LTCH standard federal 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 to December 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 proposes to codify the reinstatement process for LTCHs in new § 412.522(d)(5).

Although CMS believes the reinstatement process proposed 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 is also a proposing 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 payment rate discharges (for example, patients require a shorter period of ventilation than was expected on admission). Under this process, CMS is proposing a probationary cure period of six months. During the cure period, payment based on the IPPS comparable amount would 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 would not ultimately be 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 would 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 would be lifted, and the 2022 cost report settlement would be made using an IPPS-comparable amount for all discharges.

CMS proposes to codify the special probationary reinstatement process at § 412.522(d)(6). It further expects to issue sub-regulatory guidance to describe the specific procedures for implementing the proposed probationary cure period if the policy is finalized. CMS specifically invites public comments on whether the probationary reinstatement process should mirror the existing process used by LTCHs for the greater than 25-day average length-of-stay requirements.

The proposed rule notes that the IPPS-comparable amount is the IPPS-comparable *per diem* amount also used to calculate payments under the SSO policy and site neutral payment rate payments.

D. 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.

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

2. Proposed Annual Update for LTCHs

The proposed annual update to the LTCH PPS standard federal payment rate is equal to 2.7 percent. The update is equal to the 2013-based LTCH market basket of 3.2 percent less 0.5 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. The proposed LTCH update for FY 2020 is:

Factor	Full Update	Reduced Update for Not Submitting Quality Data
LTCH Market Basket	3.2%	3.2%
Multifactor Productivity	-0.5 PP	-0.5 PP
Quality Data Adjustment	0.0	-2.0 PP
Total	2.7%	0.70%

Area Wage Levels and Wage-Index

CMS sets out a proposed labor-related share of 66.0 percent for FY 2020 based on IGI's fourth quarter 2018 forecast of the 2013-based LTCH market basket. This is based on the sum of the labor-related portion of operating costs (61.9%) 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 proposes to compute the wage index in a manner that is consistent with prior years. Further, CMS proposes an area wage level budget neutrality adjustment, computed as in prior years, of 1.0064747.

4. Proposed LTCH Standard Federal Payment Rate Calculation

CMS proposes the following LTCH PPS standard federal payment rates for FY 2019:

FY 2020 payment rate = $41,558.68 (FY 2019 payment rate) * 1.027 (statutory update factor) * 1.0064747 (area wage budget neutrality factor) * 0.999856 (25% threshold budget neutrality factor) = $42,950.91

For LTCHs not reporting data to the LTCH QRP: FY 2020 payment rate = $41,558.68 (FY 2019 payment rate) * 1.007 (statutory update factor less quality adjustment) * 1.0064747 (area wage budget neutrality factor) * 0.999856 (25% threshold budget neutrality factor) = $42,114.47

5. 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: 0.990884 for FY 2019 and 0.990741 for FY 2020 and one 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 0.990884 adjustment and adding the 0.990741 adjustment is 0.999856.

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 2020 COLAs.

Proposed 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

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 the 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 $29,997 which CMS estimates will result in 7.9795 of LTCH standard federal payment rate cases being paid as HCOs. The HCO 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).

The proposed FY 2020 fixed-loss amount of $29,997 that applies to LTCH standard federal payment rate cases is significantly higher than the FY 2018 fixed-loss amount of $27,121. CMS states that the current FY 2019 HCO threshold of $27,121 results in estimated HCO payments for LTCH PPS standard Federal payment rate cases that exceed the 7.975 percent target by 0.265 percentage points. CMS believes this increase is largely attributable to an increase in the Medicare allowable charges in addition to updates to CCRs from the March to December update of the provider-specific file. Consistent with historical practice, CMS will use the most recent available LTCH claims data and CCR data for the final rule.

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 proposes a fixed-loss amount for site neutral payment rate cases of $26,994.

CMS also proposes 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 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) continue to 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 0.9 percent or $37 million in aggregate payments (from $4.274 billion to $4.311 billion). This estimated increase in payments reflects the projected increase in payments to LTCH PPS standard federal payment rate cases of approximately 2.3 percent ($79 million) and the projected decrease in payments to site neutral payment rate cases of approximately 4.9 percent (-$41 million estimated). CMS modeling assumes that approximately 71 percent of LTCH cases would meet the criteria for exclusion from the site neutral payment rate (that is, those cases would be paid the LTCH PPS standard federal payment rate) and approximately 29 percent of LTCH cases would be paid the site neutral payment rate (calculated using FY 2018 LTCH claims data). The increase in LTCH PPS standard federal payment rates cases results from the 2.7 percent update and a -0.1 percent one-time permanent budget neutrality adjustment for the proposed elimination of the 25-percent threshold policy as well as estimated payments for SSO cases, a portion of which are not affected by the annual update to the LTCH PPS standard federal payment rate.

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 Proposed Payment Rate and Policy Changes to LTCH PPS Payments for Standard Payment Rate Cases for FY 2020" 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.

The overall impact of LTCH PPS standard federal payment rate cases is estimated to result in an increase in aggregate LTCH payments in FY 2020 relative to FY 2019 of approximately $79 million or 2.3 percent. 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 exceed 50 percent 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 $60 million in FY 2022. The proposed rule details how CMS came up with this estimate on pages 1,775 to 1,776 of the display copy of the rule.

Summary of Impact of Proposed Changes to LTCH PPS for Standard Federal Payment Rate Cases for FY 2020*		
LTCH Classification	**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%
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 Proposed Payment Rate and Policy Changes to LTCH PPS Payments for Standard Federal Payment Rate Cases, For FY 2019," (see page 1,784 of display copy).		

Tables

The complete set of tables providing detail on the proposed 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-P.html?DLPage=1&DLEntries=10&DLSort=3&DLSortDir=descending

The information at that link comprises the following:

Table 11: MS-LTC-DRGs, relative weights, geometric average length of stay, SSO threshold, and IPPS comparable threshold for FY 2020,
Table 12A: LTCH PPS Wage Index for Urban Areas for FY 2020,
Table 12B: LTCH PPS Wage Index for Rural Areas for FY 2020,
Table 8C: LTCH PPS statewide Average Cost-to-Charge Ratios for FY 2020,
Table 13A: Composition of low-volume quintiles for MS-LTC-DRGs for FY 2020,
Table 13B: No volume MS-LTC-DRG crosswalk for FY 2020, and the
LTCH PPS FY 2020 Proposed Impact File

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 15 measures adopted for the LTCH QRP for FY 2021. This proposed rule would not change this measure list.

1. New Measures and Measure Update for FY 2022

CMS proposes 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 proposes to update 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 the proposed measures are available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/Proposed-Specifications-for-LTCH-QRP-Quality-Measures-and-SPADE.pdf. Proposed 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 proposed measure would assess 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, the measure would be 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 would be 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 would be 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.

In discussing this proposed measure, CMS reviews the literature on care transitions and the need for transfer of medication lists. CMS measure development contractors convened a Technical Expert Panel (TEP) for this measure and comments were sought on the CMS measures management system blueprint website. A summary report on these comments is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/Downloads/IMPACT_Medication-Profile-Transferred-Public-Comment-Summary-Report.pdf. A pilot test was conducted in 2018 involving 6 LTCHs and 18 other PAC providers. The pilot test summary is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/Downloads/Transfer-of-Health-Information-2018-Pilot-Test-Summary-Report_Final.pdf. The Measure Applications Partnership conditionally supported the measure pending endorsement by the National Quality Forum and suggested that the medication information transferred include information about supplements and opioids. CMS identified a related NQF-endorsed measure "Documentation of Current Medications in the Medical Record" (NQF #0419) but believes that the proposed measure better addresses the Transfer of Health Information domain because NQF #0419 does not address the transfer of medication information, only the documentation of it. In addition, the domain requires that at least some of the data used to calculate the measure be collected as standardized patient assessment data through the PAC assessment instruments.

- Transfer of Health Information to the Patient -- PAC Measure. This related proposed new measure would assess 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 same links provided for the proposed measure above include information on the public comments and pilot testing of this measure. The MAP also conditionally supported this measure. No similar NQF-endorsed measure was identified. The measure denominator would be the total number of LTCH patient stays ending in discharge to the locations listed above, and the numerator would be 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. CMS proposes to update the specifications for this measure to remove baseline nursing facility residents. 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. Under the proposal, CMS would exclude baseline NF residents from the measure beginning with the FY 2020 LTCH QRP, with baseline NF residents 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.

Based on previous comments supporting this change, CMS analyzed the impact and found that after excluding baselined NF residents, 39 percent of LTCHs had an increase in their risk-standardized discharge to community rate that exceeded the national observed patient-level discharge to community rate.

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

CMS seeks 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 will not respond to these comments in the final rule, but they 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 the FY 2018 IPPS/LTCH proposed rule (82 FR 20100-20116), CMS proposed to require LTCHs to report 23 SPADEs, but only 2 were ultimately finalized. Commenters had raised a

general concern that CMS was moving too quickly given the other IMPACT Act requirements also being adopted at that time and had specific concerns that the proposed SPADEs needed further testing. The SPADEs that were finalized address two IMPACT Act categories (1) Functional status: Data elements currently reported by LTCHs to calculate the measure Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function and (2) Medical conditions and morbidities: data elements used to calculate the pressure ulcer measures.

In this rule, CMS proposes again to require LTCHs to report a new series of SPADEs, most of which are the same or modifications of the SPADEs that were previously proposed and not finalized. The list of proposed SPADEs, along with information on their current use in PAC patient assessment instruments and whether changes would be needed to the LCDS are summarized in a table below. Detailed specifications for the proposed SPADEs are available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/Proposed-Specifications-for-LTCH-QRP-Quality-Measures-and-SPADE.pdf. A change table and mockup of proposed 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 proposed data elements associated with the proposed new transfer of health information measures discussed above.

The required reporting would begin with the FY 2022 LTCH QRP. Under the proposal, for FY 2022 the data would 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 would 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 proposed SPADE, CMS offers a rationale, discusses whether the element is currently used in any PAC patient assessment instruments, and describes past comments from stakeholders and pilot testing. The following are the proposed SPADEs that were not part of those proposed in FY 2018 rulemaking:

- Functional Status. Six mobility-related data elements that have been adopted for the other three PAC settings are proposed for addition to the LCDS. CMS notes that the statute requires that SPADEs apply to all four settings.
- High-Risk Drug Classes: Use and Indications. This proposed new data element would ask at admission and discharge whether the patient is taking any medications in 6 specific drug classes, and if so, whether there is an indication noted for all the medications in the drug class. The six drug classes are antipsychotics, anticoagulants, antibiotics, opioids, antiplatelets, and hypoglycemics (including insulin). In describing its proposal, CMS cites the literature on the potential adverse effects associated with these drugs and discusses comments it received from stakeholders during the development process.
- Pain Interference (Pain Effect on Sleep, Pain Interference with Therapy Activities, and Pain Interference with Day-to-Day Activities). This proposed new data element would assess at admission and discharge the frequency with which pain effects a patient's sleep, ability to participate in therapy activities, and other day-to-day activities. In discussing

this proposal, CMS reviews changes in the practice of pain management and the literature on complications from opioid use in the elderly. It believes this proposal will support PAC clinicians in applying best practices in pain management consistent with current guidelines.

- Social Determinants of Health. This is a new category of SPADEs that would collect data on social determinants of health using existing PAC data collection mechanisms. CMS describes the requirements in the IMPACT Act for the Secretary to assess adjustments to quality and resource use measures to reflect social risk factors, including establishing new data sources. CMS believes that use of existing patient assessment instruments would be less burdensome on providers. Work by the Assistant Secretary for Planning and Evaluation and the National Academies of Sciences, Engineering and Medicine (NASEM) on social risk factors in response to the IMPACT Act requirements is reviewed.

  Seven SPADEs are proposed consistent with a 2016 NASEM report on identifying social risk factors:[36] race, ethnicity, preferred language, interpreter services, health literacy, transportation, and social isolation. In the case of race and ethnicity and preferred language, the LCDS already collects this information on admission, but the current items would be revised. Data on all these proposed SPADEs would be collected at admission and discharge, but in the case of race and ethnicity, collection at admission would be deemed to meet both requirements because the information would be unlikely to change. Three of the proposed items under the social determinants of health categories are not currently used in any PAC patient assessment instrument. The health literacy item would ask how often the patient needs to have someone help read instructions, pamphlets or other written materials from the doctor or pharmacy. (The five responses are never, rarely, sometimes, often and always.) In discussing its proposal CMS reviews the testing of this question and compares it to other health literacy screening tools. The proposed transportation item comes from the Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PROMISE) assessment tool and is currently part of the Accountable Health Communities (AHC) screening tool used by the CMS Innovation Center for the AHC program. It would ask the patient whether lack of transportation has kept them from medical appointments, meetings, work or from getting things needed for daily living. The three responses are: (1) Yes, it has kept me from medical appointments or getting medications, (2) Yes, it has kept me from non-medical meetings, appointments, work or getting things I need, and (3) No. Finally, the social isolation item is also part of the AHC screening tool. It comes from the Patient-Reported Outcomes Measurement Information System (PROMIS®) Item Bank on Emotional Distress. It would ask patients how often they feel lonely or isolated from those around them, with the same five possible responses as the health literacy question.

With respect to the proposed Hearing, Vision, Race, and Ethnicity SPADEs, CMS proposes that LTCHs submitting these SPADEs with respect to admission only would be deemed to have

[36] National Academies of Sciences, Engineering, and Medicine. 2016. *Accounting for social risk factors in Medicare payment: Identifying social risk factors*. Chapter 2. Washington, DC: The National Academies Press.

submitted them for both admission and discharge, because it is unlikely that assessment of these SPADEs would change during the LTCH stay.

In proposing the SPADEs, CMS says that it considered provider burden as well as overall clinical relevance; interoperable exchange to facilitate care coordination during transitions in care; ability to capture medical complexity and risk factors that can inform both payment and quality; and scientific reliability and validity and consensus agreement for its usability. The specific SPADEs proposed were identified through feedback from stakeholders, TEPs, and the results of a national beta test of candidate elements conducted by a CMS contractor. That test collected data from 3,121 patients and residents across LTCHs, SNFs, IRFs, and HHAs between November 2017 and August 2018. Information on the methods and results can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/Downloads/Development-and-Evaluation-of-Candidate-SPADEs_National-Beta-Test-Background-and-Methods.pdf. Results from the PAC Payment Reform Demonstration (PAC PRD) of 2006 – 2012 were also considered. Summaries of the several TEPs that discussed these data elements and comments received in that process 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.

In the collection of information requirements section of the proposed rule CMS estimates that the proposed changes to the LTCH QRP would require additional data collection efforts and annual costs would total about $5,500 per LTCH or $2.3 million across all LTCHs.

Proposed 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
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	New item

Proposed Standardized Patient Assessment Data Elements, by Category		
Data Elements	**Current Use/Test of Elements***	**Change to LCDS**
	PAC PRD	
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	
Ethnicity	LCDS IRF-PAI	Modify LCDS items**

Proposed Standardized Patient Assessment Data Elements, by Category		
Data Elements	**Current Use/Test of Elements***	**Change to LCDS**
	OASIS	
Preferred Language and Interpreter Services	MDS LCDS	Modify LCDS item
Health Literacy		New item
Transportation	PREPARE/AHC screening tool	New item
Social Isolation	PROMISE/AHC screening tool	New item
*This column reflects whether the proposed rule indicates that the specific elements proposed, 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 would 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 CMS proposes 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

CMS proposes to move the implementation date of any new version of the LCDS from April to October, beginning October 1, 2020. This would align 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 would 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 would 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 would be May 15, 2021. The proposed rule includes a table displaying the reporting deadlines for data reported in 2021 for FY 2023 payment.

Schedule for Reporting Proposed Transfer of Health Information Quality Measures and SPADES

As summarized in section VIII.C.1 above, two new measures are proposed beginning with FY 2022 payment. CMS proposes that LTCHs would be required to collect data for these measures beginning with patients discharged on or after October 1, 2020. The initial reporting schedule described above would apply.

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

5. Remove of the List of Compliant LTCHs

CMS proposes to 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

CMS proposes to add the LTCH QRP measure "Drug Regimen Review Conducted with Follow-Up for Identified Issues" to the *Long Term Care Hospital Compare* website at https://www.medicare.gov/longtermcarehospitalcompare/.

Display would begin with 2020 or as soon as technically feasible. The data display would 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 would not be publicly displayed. For those LTCHs, the website would 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**
NHSN Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138)	X	X	X
NHSN Central line-associated Blood Stream Infection (CLABSI) Outcome Measure (NQF #0139)	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	

LTCH QRP Measures, by Year			
Measure Title	**FY 2019**	**FY 2020**	**FY 2021**
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
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
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
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
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
Change in Mobility among Long-Term Care Hospital Patients Requiring Ventilator Support (NQF #2632)	X	X	X
NHSN Ventilator Associated Event Outcome Measure	X	X	Removed
Medicare spending per beneficiary MSPB-PAC LTCH	X	X	X
Discharge to Community PAC LTCH	X	X	X
Potentially Preventable Readmissions 30 Days Post LTCH Discharge	X	X	X
Drug Regimen Review Conducted with Follow-up		X	X
Mechanical Ventilation Process Measure: Compliance with Spontaneous Breathing Test by Day 2 of the LTCH Stay		X	X
Mechanical Ventilation Outcome Measure: Ventilator Liberation Rate		X	X