

August 17, 2017

LONG-TERM CARE HOSPITAL PPS: THE FINAL RULE FOR FY 2018

AT A GLANCE

The Issue:

On Aug. 14, the Centers for Medicare & Medicaid Services (CMS) published its fiscal year (FY) 2018 [final rule](#) for the inpatient and long-term care hospital (LTCH) prospective payment systems (PPS). This advisory covers the rule's LTCH-related provisions; we are issuing a separate advisory on the rule's inpatient PPS provisions. For FY 2018, when combining the impact of the LTCH PPS standard rate update (1 percent increase) with the update to site-neutral payments (20 percent decrease), plus other changes in the rule, LTCHs will face a net payment decrease of 2.4 percent, or -\$110 million, from FY 2017 levels. In addition, the rule implements a regulatory pause on full implementation of the LTCH 25% Rule during FY 2018, which will be a seamless extension of statutory relief scheduled to conclude at the end of FY 2017. For the LTCH Quality Reporting Program, CMS will add two new measures, remove one readmission measure and replace a measure regarding pressure ulcers. CMS has significantly scaled back its proposal to require the reporting of certain standardized patient assessment data as mandated by the Improving Medicare Post-Acute Care Transformation Act of 2014.

Our Take:

We are pleased that CMS responded to AHA's call for 25% Rule relief, which will both improve access to care and reduce LTCHs' regulatory burden. We continue to urge the agency to permanently remove the policy. The combination of the 25% Rule and site-neutral payment is unwarranted and would have created major access challenges for the severely ill patients treated in LTCHs. However, we continue to be concerned about and opposed to the continued application of duplicative budget-neutral adjustments for site-neutral cases, as the redundant adjustment represents a systematic and sizeable underpayment. Additionally, AHA appreciates that CMS has acknowledged our concerns regarding the expanded patient assessment data reporting requirements and has scaled back its proposal to add several items to the already lengthy LTCH CARE data set. However, we continue to have concerns regarding the two new quality measures and the validity of the data they would report.

What You Can Do:

- ✓ Share the attached summary with your senior management team to examine the affect these changes will have on your organization for FY 2018.
- ✓ **Participate in the AHA-member call to discuss this LTCH rule on Tuesday, Aug. 29 at 3 p.m. ET.** Click [here](#) to register in advance.

Further Questions:

For questions on the rule's payment provisions, contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org. For quality-related questions, contact Caitlin Gillooley, associate director of policy, at cjillooley@aha.org.

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BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) published its fiscal year (FY) 2018 [final rule](#) for the hospital inpatient and long-term care hospital (LTCH) prospective payment systems (PPS) in the Aug. 14 Federal Register. This regulatory advisory covers the rule's LTCH-related proposals; a separate advisory summarizes the inpatient PPS provisions.

This rule updates payments for the dual-rate LTCH PPS for FY 2018, which includes both LTCH standard rate and site-neutral rate cases. When combining the estimated impact of the LTCH PPS standard rate update (+1.0 percent or \$35 million increase) with the impact of the site-neutral payment component (-20.0 percent or \$230 million decrease), and other changes, CMS estimates that LTCHs will face a net decrease of 2.4 percent, or -\$110 million, relative to FY 2017. In addition, the rule implements a regulatory pause on full implementation of the LTCH 25% Rule during FY 2018, which will be a seamless extension of statutory relief scheduled to conclude at the end of FY 2017. Further, for the LTCH Quality Reporting Program (QRP), CMS will add two new measures, remove one readmission measure and replace a measure regarding pressure ulcers. CMS also has significantly scaled back its proposal to require the reporting of certain standardized patient assessment data as mandated by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014.

UPDATE TO THE LTCH PPS STANDARD RATE

CMS estimates that, under Medicare's dual-rate system for LTCHs, in FY 2018, 58 percent of cases will qualify for a LTCH PPS standard payment – an increase from 55 percent in FY 2017. The remaining cases will be paid a site-neutral rate.

FY 2018 Standard Rate

For FY 2018, CMS finalized a payment update of 1.0 percent, as required by the Medicare Access and CHIP Reauthorization Act. However, the final FY 2018 standard rate for LTCHs reporting required quality data will decrease from the FY 2017 rate of \$42,476.41 to \$41,430.56 due to two negative budget neutrality adjustments to the standard rate to account for the area wage index and short-stay outliers, as discussed below.

Medicare-Severity Long-term Care Diagnosis Related Group (MS-LTC-DRG) Weights

For FY 2018, CMS will re-weight the MS-LTC-DRG relative weights using the same methodology as prior years, including the exclusion of site-neutral eligible cases. The rule's online addendum lists the final MS-LTC-DRGs and their respective relative weights, average length of stay (ALOS) and geometric mean length-of-stay (used to identify short-stay outliers). The rule reduces the number of DRGs from 757 to 754. Of these, in keeping with the prior re-weighting approach, the rule identified 262 "low-volume MS-LTC-DRGs" (those with fewer than 25 LTCH cases) for FY 2018, an increase from 259 in FY 2017, which are grouped into quintiles, with each quintile assigned a relative weight. The "no-volume MS-LTC-DRGs" are weighted based on other MS-LTC-DRGs that are clinically similar and have similar costliness. We note that, under the new dual-rate structure, the number of no-volume MS-LTC-DRGs continues to grow, with 348 finalized for FY 2018, a substantial increase from 247 in FY 2015, the year preceding the implementation of the dual-rate payment system.

Labor-related Share

The labor-related share is the portion of total LTCH costs that are related to, influenced by or vary with the local labor market, such as wages, salaries and benefits. The final FY 2018 labor-related share will be 66.2 percent, a slight drop from the FY 2017 rate of 66.5 percent. The labor-related share is implemented in a budget-neutral manner to avoid any change to aggregate LTCH PPS payments.

Area Wage Index

As in prior years, the LTCH PPS wage index will be computed using wage data from general acute-care hospitals, without adjustments for geographic reclassification, and updated in a budget-neutral manner. To calculate the budget-neutrality adjustment for wage index changes from FYs 2017 to 2018, CMS uses only claims that would qualify for a standard LTCH PPS payment. For FY 2018, the rule established an area wage index budget-neutrality factor of 1.0006434.

New Short-stay Outlier (SSO) Methodology

CMS finalized a new SSO payment policy, which applies to LTCH standard rate cases only, while retaining the current SSO definition. The agency states that it wants to remove the incentive to delay the discharge of a short-stay patient until just beyond the short-stay threshold, since doing so makes the case eligible for a full LTCH PPS payment, rather than the substantially reduced short-stay payment. Under the final policy, all SSO cases will be paid a graduated blend of the inpatient PPS per-diem amount and 120 percent of the MS-LTC-DRG per diem amount. The MS-LTC-DRG portion of this blend will increase as the length of stay increases. As a result, very short-stay cases will receive an amount more like an inpatient PPS case; relatively longer short-stay cases will receive an amount more like a standard LTCH PPS case. CMS estimates that under the new SSO policy, aggregate payments will increase by approximately \$112 million; therefore, CMS finalized a budget neutrality adjustment of 0.9651 to avoid increasing overall payments.

Adjustment for LTCH PPS High-cost Outlier (HCO) Cases

CMS finalized a HCO threshold of \$27,382 (proposed threshold was \$30,081) for standard rate cases, which is significantly higher than the FY 2017 threshold of

\$21,943. This change will result in fewer cases receiving HCO payments in order to align with a 7.975 percent HCO pool, which was reduced from the typical 8.0 percent pool in the 21st Century Cures Act. CMS estimated that without raising this threshold, outlier payments would be 8.1 percent of total payments. Concerning the notably higher threshold, CMS states, “As was the case when there were fluctuations in the fixed-loss amount in the early years of the LTCH PPS, we expect annual changes to the fixed-loss amount to generally stabilize as experience is gained under the new dual-rate LTCH PPS payment structure.” The agency also states that, “...it is appropriate to continue to use our historical approach until we gain experience with the effects and implementation of the dual-rate LTCH PPS payment structure...” We note that while CMS now uses a 7.975 target when setting the HCO outlier threshold, the 8.0 target is still used when CMS sets LTCH standard payment rates.

LTCH SITE-NEUTRAL PAYMENT RATES

Per the Bipartisan Budget Act of 2013 (BiBA), LTCH site-neutral cases:

- Have a principal LTCH diagnosis related to a psychiatric or rehabilitation condition; or
- Are not transferred within one day from a general acute-care hospital to a LTCH; or
- Lack either three or more days of care in an intensive care unit or coronary care unit during the prior hospital stay, and a qualifying procedure code for 96+ hours of ventilator care in the LTCH.

CMS implemented site-neutral payment on a rolling basis, starting with cost-reporting periods that began on or after Oct. 1, 2015. For the first two cost-reporting periods under the new system, site-neutral cases are paid a 50/50 blend of LTCH PPS and site-neutral rates. However, the blended rate will not apply to cost reporting periods starting on or after Oct. 1, 2017. Instead, these site-neutral cases will be fully paid using the site-neutral methodology required in statute: the lesser of the inpatient PPS-comparable per-diem amount, plus any outlier payments, or 100 percent of the estimated cost of the case. CMS estimates that 42 percent of cases in FY 2018 will meet site-neutral criteria.

Budget Neutrality Adjustments

CMS will continue applying a 5.1 percent budget neutrality adjustment (BNA) to the site-neutral payment amount because it believes that this is necessary to avoid increasing aggregate FY 2018 LTCH PPS payments, in comparison to what LTCHs would be paid if the payment system has no site-neutral element. However, since the inpatient PPS rates used to pay site-neutral cases have already been reduced by 5.1 percent to ensure budget neutrality for inpatient PPS outlier payments, the AHA contends that this “second” 5.1 percent BNA applied within the LTCH framework is redundant and represents a systematic reduction of LTCH site-neutral payments. We have argued this point in our comments on the proposed rules for FYs 2016 and 2017. Unfortunately, CMS continues to disagree with our position on this issue.

Adjustment for Site-neutral, High-cost Outlier Cases

To calculate HCO payments for site-neutral cases, if the base payment for the claim exceeds the HCO threshold (calculated by adding inpatient PPS-comparable per diem amount plus the inpatient PPS fixed-loss amount), a LTCH receives a payment add-on equal to 80 percent of the amount beyond the HCO threshold. For FY 2018, the LTCH HCO threshold, which is “borrowed” from the inpatient PPS, will increase from the FY 2017 rate of \$23,681 to \$26,601. CMS is continuing to use the inpatient PPS threshold since its projects that when the site-neutral payment system is fully implemented, the cost and resource use of site-neutral cases will become more aligned with inpatient PPS costs assigned to the same MS-DRG.

25% RULE RELIEF

Under the 25% Rule, which CMS first implemented in FY 2005, admissions from a particular referring hospital that exceed an annual threshold are subject to a payment reduction from a LTCH standard rate to an inpatient PPS equivalent rate. Congress has provided relief from full implementation of this policy through several pieces of legislation, beginning with the Medicare, Medicaid and SCHIP Extension Act of 2007. Most recently, the 21st Century Cures Act provided relief for LTCH discharges from Oct. 1, 2016 through Sept. 30, 2017. Federal law already has granted a permanent exemption from the policy to co-located “grandfathered hospitals.”

We are pleased that, as proposed, CMS will not implement the LTCH 25% Rule during FY 2018. Instead, CMS will seamlessly extend for 12 months the statutory moratorium that is scheduled to expire after Sept. 30. The rule notes that this pause will allow the agency to study the impact of site-neutral payment without the behavioral impact of the 25% Rule. Specifically, CMS states that it plans to examine whether the LTCH site-neutral payment system renders the 25% Rule unnecessary. CMS also notes that under these multiple 25% Rule moratoria, a gap period (cost reporting periods beginning on or after July 1 and before Oct. 1 2016) exists during which the policy was in full effect. However, the agency believes very few LTCHs in this category will be subject to the policy.

CHANGES MANDATED BY THE 21ST CENTURY CURES ACT

Site-neutral Relief for Qualifying “Spinal Cord Specialty Hospitals”

The 21st Century Cures Act provides qualifying “spinal cord specialty hospitals” with a temporary exemption from site-neutral payment. CMS estimates that two LTCHs will meet the criteria for this relief, which provides LTCH standard rate payment for all discharges during cost reporting periods beginning in FYs 2018 and 2019. The criteria for this relief include that an LTCH:

- was a not-for-profit LTCH on June 1, 2014, as determined by cost report data;
- at least 50 percent of its discharges in calendar year 2013 were made under MS-LTC-DRGs 28, 29, 52, 57, 551, 573, or 963; and
- had inpatients during FY 2014 from at least 20 of the 50 states.

As noted in the proposed and final rules, CMS plans to issue further details on this provision through sub-regulatory guidance.

Site-neutral Relief for Qualifying Severe Wounds Cases

The rule finalizes without modification CMS's proposals to implement the 21st Century Cures Act's relief from site-neutral payment for qualifying severe wound cases. This relief follows similar site-neutral payment relief for certain *rural*, severe wound cases under the Consolidated Appropriations Act of 2016, which applied to qualifying rural LTCHs from April 21, 2016 through Jan. 1, 2017. Specifically, the 21st Century Cures Act authorized a site-neutral payment exemption for severe wound cases for discharges occurring in cost reporting periods beginning during FY 2018. This new relief applies to co-located LTCHs that participated in Medicare prior to Oct. 1, 1995; does not require that the LTCH have rural status; and includes criteria that are narrower than the initial set:

- discharges with MS–LTC–DRG 602, 603, 539, or 540; and
- a Stage 3, Stage 4, unstageable, non-healing surgical, or fistula as identified in the claim.

Moratorium Exception Changes for New LTCH Beds

The rule finalizes without modification its statutorily required proposal to expand the current LTCH moratorium to include new beds. The most recent moratorium on new facilities and beds was authorized by the Protecting Access to Medicare Act of 2014 (PAMA) and is in effect from April 2014 through September 2017. The PAMA moratorium includes exceptions that only apply to LTCH facilities – not beds. However, the 21st Century Cures Act expanded the facility moratorium exceptions to include new bed expansions planned as of April 1, 2014, which, under this rule, takes effect during the moratorium time period set by PAMA.

Changes to the ALOS Criterion

To be a LTCH, a hospital must maintain an ALOS that is greater than 25 days. Prior to the 21st Century Cures Act, site-neutral cases and Medicare Advantage cases were excluded from the ALOS calculation for hospitals classified as a LTCH as of Dec. 10, 2013. However, this legislation requires CMS to apply this methodology to all LTCHs. CMS implements this provision as proposed.

In addition, this section of the rule recognizes comments received from the field that favor the complete removal of the LTCH ALOS criteria. In response, CMS notes that these comments were outside the scope of the proposed rule and that this criterion is a statutory requirement that the agency lacks the authority to change. However, the agency also states that it, “may consider the possibility of refining the method of calculating whether an LTCH has maintained the requisite average length of stay in future rulemaking.”

Change in Medicare Classification for the Cancer LTCH

CMS finalized without modification its proposal to codify the 21st Century Cures Act requirements related to the single “cancer LTCH,” which BiBA mandated be paid under reasonable cost-based payment methodology commonly referred to as “TEFRA,”

instead of LTCH PPS payments. Specifically, the agency will establish a new regulatory category for this hospital, “long-term care neoplastic disease hospitals.” The rule also sunsets the LTCH PPS regulations that applied to this hospital before this BiBA-authorized change, effective for cost reporting periods that begin on or after Jan. 1, 2015.

CHANGES TO HOSPITAL WITHIN HOSPITAL SEPARATENESS CRITERIA

Beginning Oct. 1, CMS is narrowing the scope of the “separateness criteria” that an LTCH must meet to be designated a hospital within hospital (HwH) on the campus of a host hospital. These criteria, for example, require that the HwH have a separate governing body, chief executive and medical officers, and medical staff. Under the final rule, these criteria will now apply only if the HwH’s host hospital is an inpatient PPS hospital. In addition, in a slight modification to the proposed rule, CMS eliminated all of the “basic hospital functions” from the HwH qualification criteria. CMS characterizes this change as administrative with no affect on hospital operations. The rule reviews the initial implementation of these criteria in 1994 and their subsequent evolution, noting that their initial purpose was to prevent LTCHs from being treated as hospital units, which would allow the host to receive far higher payments for cases transferred to the LTCH. The rule notes that this underlying concern is now “sufficiently moderated” when two IPPS-excluded hospitals are co-located, due to policies changes clarifying which types of patients may be treated in excluded settings, which include inpatient psychiatric and inpatient rehabilitation hospitals.

Further detail on this policy are provided in the Medicare regulations at [§ 412.22\(f\)](#).

LTCH QUALITY REPORTING PROGRAM (LTCH QRP)

The Affordable Care Act mandated that reporting of quality measures for LTCHs begin no later than FY 2014. Failure to comply with LTCH QRP requirements will result in a 2 percentage point reduction to the LTCH’s annual market-basket update.

CMS finalizes the adoption of two new measures and one revised measure for the LTCH QRP to meet the requirements of the IMPACT Act. These measures will be adopted for the FY 2020 LTCH QRP with data reported on discharges on or after April 1, 2018. The IMPACT Act is intended to foster greater standardization and alignment of measures across CMS’s post-acute care quality reporting programs, including the LTCH QRP. A detailed summary of the IMPACT Act’s requirements can be found in the AHA’s Oct. 16, 2014 [Legislative Advisory](#). Table 1 below summarizes the finalized measures for the LTCH QRP.

In addition, CMS will require LTCHs to collect certain standardized patient assessment data beginning with LTCH admissions on or after April 1, 2018 to meet requirements of the IMPACT Act.

Table 1: Finalized Measures for the LTCH QRP, FY 2017 – FY 2020

Measure	FY 2017	FY 2018	FY 2019	FY 2020
Central line-associated blood stream infection (CLABSI)	X	X	X	X
Catheter-associated urinary tract infection (CAUTI)	X	X	X	X
Percent of residents or patients with pressure ulcers that are new or worsened	X	X	X	-
Percent of residents or patients who were assessed and appropriately given the seasonal influenza vaccine	X	X	X	X
Influenza vaccination coverage among health care personnel	X	X	X	X
<i>Methicillin-resistant Staphylococcus aureus</i> bacteremia	X	X	X	X
<i>Clostridium difficile</i> bacteremia	X	X	X	X
Unplanned all-cause, all-condition readmissions for 30-day post-discharge from LTCHs	X	X		
Percent of residents experiencing one or more falls with major injury (Long stay)		X	X	X
Functional Status: Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function		X	X	X
Functional Status: Change in mobility among LTCH patients requiring ventilator support		X	X	X
Ventilator-associated Event Outcome Measure		X	X	X
Medicare spending per beneficiary for post-acute care LTCH QRP (MSPB – LTCH)		X	X	X
Discharge to community – PAC LTCH		X	X	X
Potentially preventable 30-day post-discharge readmission measure for LTCH QRP			X	X
Drug regimen review conducted with follow-up for identified issues				X
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury				X
Compliance with spontaneous breathing trial by day 2 of stay				X
Ventilator Liberation Rate				X

X = Finalized

FY 2019 and FY 2020 Measurement Changes

CMS finalizes the adoption of three new measures for the FY 2020 LTCH QRP and the removal of one measure. Detailed specifications for the measures are available on CMS’s LTCH QRP [website](#).

Changes in Skin Integrity Post-acute Care: Pressure Ulcer/Injury. CMS will remove the current pressure ulcer measure in the LTCH QRP, Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay), and replace it with a modified version of that measure, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury. This modified version includes new or worsened unstageable pressure ulcers, including deep tissue injuries (DTIs), in the measure numerator in addition to Stage 2, 3, and 4 pressure ulcers. This modified measure satisfies the requirements of the IMPACT Act domain of skin integrity and changes in skin integrity.

The current measure is calculated using retrospective data elements that assess the number of new or worsened pressure ulcers at each stage, while the new measure is calculated using the number of unhealed pressure ulcers at each stage after subtracting

the number that were present upon admission. The data for this measure will be collected using the LTCH CARE data set (LCDS), which is currently submitted by LTCHs through the QIES ASAP System. In the final rule, CMS notes that they will provide training and guidance prior to implementation to promote consistency in the interpretation of the measure and will update the LTCH QRP manual with additional examples to further address the coding of unstageable pressure ulcers and those that are “present on admission.”

In response to several comments on the FY 2018 LTCH PPS proposed rule, CMS clarifies that the definitions it uses for pressure ulcers are adapted from the National Pressure Ulcer Advisory Panel.

Compliance with Spontaneous Breathing Trial (SBT) by Day 2 of the LTCH Stay. This process measure is one of two ventilator weaning measures CMS has adopted in the LTCH QRP for FY 2020. This measure assesses facility-level compliance with SBT, including TCT or CPAP breathing trial, by the day after admission. The measure is calculated and reported separately for two components:

- The percentage of patients admitted on invasive mechanical ventilation who were *assessed for readiness* for SBT by day 2 of the LTCH stay: The denominator includes total number of patients admitted during the reporting period who were on invasive mechanical ventilation upon admission and expected or anticipated by the provider to undergo weaning attempts at admission. The numerator includes the number of patients admitted on invasive mechanical ventilation during the reporting period who were assessed for readiness for SBT (including TCT or CPAP breathing trial) by day 2 of the stay.
- The percentage of patients *deemed medically ready for SBT and received* SBT by day 2 of the LTCH stay: The denominator is the subset of patients in the first component who were assessed and deemed ready for SBT by day 2. The number includes the number of patients admitted on invasive mechanical ventilation during the reporting period who were ready for SBT and who received an SBT by day 2.

The measure was developed following refinement of the measure’s technical specifications by a technical expert panel (TEP), public comment, and a pilot test of the data elements with 10 LTCHs and approximately 150 LTCH patients. The data for this measure will be collected through the LCDS, with submission through the Quality Improvement and Evaluation Assessment Submission and Processing (QIES ASAP) system; CMS will revise the LCDS to include new items that assess processes for weaning from invasive mechanical ventilation.

Ventilator Liberation Rate. This outcome measure is the second of the two new measures related to ventilator weaning. This measure is also a facility-level measure that reports the percentage of LTCH patients admitted on invasive mechanical ventilation for whom weaning attempts were expected or anticipated (as reported on the Admission Assessment) and are fully weaned by the end of their LTCH stay. CMS defines “fully weaned” as those who did not require any invasive mechanical ventilation support for at least two consecutive calendar days immediately prior to discharge.

The measure is risk-adjusted for variable such as age, neurological injury or disease, dialysis, and other comorbidities and treatments. If a patient has more than one LTCH stay during the reporting period, then each LTCH stay will be included in the measure calculation and reporting. Data for this measure will be collected through LCDS, with the submission through the QIES ASAP system; CMS will revise the LCDS to include new items that assess invasive mechanical ventilation liberation at discharge.

The measure was developed following input from a TEP, which provided guidance on inclusion and exclusion criteria as well as patient demographic and clinical factors that could affect ventilator weaning outcomes to inform risk adjusters. After a public comment period, the measure was evaluated in a pilot test in 10 LTCHs and approximately 150 LTCH patients.

All-cause Unplanned Readmission Measure for 30 Days Post-Discharge from LTCHs. CMS will remove this measure beginning with the FY 2019 LTCH QRP after receiving public comments regarding the multiplicity of readmission measures and the overlap between this measure and the newly introduced Potentially Preventable Readmission 30-Day Post-Discharge measure. Public reporting of this measure will end by October 2018 when public reporting of the Potentially Preventable Readmission measure begins by October 2018. **AHA supports the removal of this measure.**

Standardized Patient Assessment Data Reporting: FY 2019 and FY 2020

In addition to requiring standardization and alignment of quality measures, the IMPACT Act also requires the collection of standardized patient assessment data. **The reporting of these data is made a requirement of the post-acute care (PAC) quality reporting programs, and as a result, failure to comply with the requirements will result in a payment reduction.** Currently, each PAC setting collects different patient assessment data in setting-specific tools. The LTCH setting collects this data in the LCDS, whereas skilled nursing facilities, inpatient rehabilitation facilities, and home health agencies collect different data elements in their own tools—the Minimum Data Set (MDS) 3.0, Patient Assessment Instrument (PAI), and Outcome and Assessment Information Set (OASIS), respectively.

According to the IMPACT Act, the standardized patient assessment data elements must satisfy five domains specified by CMS, which include functional status, cognitive function, special services, medical conditions and comorbidities, and impairments. Some of the items have been tested, either for individual settings or in the PAC Payment Reform Demonstration (PRD) study, and are already implemented in some settings.

FY 2019 Requirements. The IMPACT Act requires LTCHs to report standardized patient assessment data starting with the FY 2019 LTCH QRP. CMS has determined that the data elements used to calculate the current pressure ulcer measure (Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened, Short Stay) meet the definition of standardized patient assessment data with respect to the “medical conditions and co-morbidities” domain. Thus, successful reporting of that data for admissions and discharges during the last three quarters of CY 2017 will satisfy the requirement to report standardized patient assessment data for the FY 2019 LTCH QRP.

FY 2020 Requirements. In the FY 2018 LTCH PPS proposed rule, CMS proposed a list of additional data elements that would fulfil the other domains required by the IMPACT Act. The adoption of these data elements would have meant the addition of several new items to the LCDS, and many existing elements would have to be modified or expanded to meet the requirements that the elements be standardized across all PAC settings. AHA and other stakeholders voiced concerns that these changes and additions, required for implementation in a very short time period, would result in enormous burden on post-acute care providers. **In response to these concerns, CMS will not require the implementation of data elements in three of the five categories mandated by the IMPACT Act for FY 2020. These categories are Cognitive Function, Special Services and Treatments, and Impairments.**

CMS finalized its proposal to require LTCHs to report data on two of the three categories for FY 2020: Functional Status and Medical Conditions and Comorbidities. However, CMS states that the data elements already required to calculate existing measures (Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function and the newly finalized Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury) are sufficient to meet the standardized patient assessment data requirements for these two categories. LTCHs will be required to report this data with respect to admissions and discharges that occur between April 1, 2018 and Dec. 31, 2018. Following this initial reporting year, subsequent years for the LTCH QRP will be based on a full calendar year of data reporting. In addition, CMS finalized its proposal to extend the current administrative requirements for quality data to the patient assessment data, which includes:

- Participation
- Exception and Extension
- Reconsiderations
- Data completion thresholds

Below in Table 2 is the list and our analysis of proposed data elements, including whether they currently exist in the LCDS or other PAC tools, whether they were tested in the PAC PRD, and whether they will be required as part of the reporting of standardized patient assessment data for FY 2020. The data elements that currently exist in the LCDS are still required for reporting by LTCHs, but will not be tied to the administrative requirements for standardized patient assessment data reporting in FY 2020.

Table 2. AHA Analysis of Finalized Standardized Patient Assessment Data Elements

Domain	Element	Currently in LCDS?	Currently in other PAC tool?	Number of items	Required for FY 2020?
Functional Status	Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function	Yes (CARE Item set)	MDS 3.0, IRF-PAI	1	Yes
Cognitive Function & Mental Status	Brief Interview for Mental Status (BIMS)	No	MDS 3.0, IRF-PAI	7	No
	Confusion Assessment Method (CAM)	Yes	MDS 3.0	6	No
	Behavioral Signs and Symptoms	No	MDS 3.0, OASIS-C2	3	No
	Patient Health Questionnaire-2	No	MDS 3.0, OASIS-C2	2	No
Special Services, Treatments, and Interventions	Cancer Treatment: Chemotherapy (IV, Oral, Other)	No	MDS 3.0 (principal)	1-4 (1 principal; 3 sub)	No
	Cancer Treatment: Radiation	No	MDS 3.0	1	No
	Respiratory Treatment: Oxygen Therapy (Continuous, Intermittent)	No	MDS 3.0, OASIS-C2	1-2 (1 principal; 2 sub either/or)	No
	Respiratory Treatment: Suctioning (Scheduled, As needed)	No	MDS 3.0	1-2 (1 principal; 2 sub either/or)	No
	Respiratory Treatment: Tracheostomy Care	No	MDS 3.0	1	No
	Respiratory Treatment: Non-invasive Mechanical Ventilator (BiPAP, CPAP)	Yes (principal)	MDS 3.0, OASIS-C2	1-3 (1 principal; 2 sub)	No
	Respiratory Treatment: Invasive Mechanical Ventilator	Yes	MDS 3.0	1	No
	Other Treatment: Intravenous (IV) Medications (Antibiotics, Anticoagulation, Other)	No	MDS 3.0 (principal) OASIS-C2	1-4 (1 principal; 3 sub)	No
	Other Treatment: Transfusions	No	MDS 3.0, OASIS-C2	1	No
	Other Treatment: Dialysis (Hemodialysis, Peritoneal dialysis)	Yes (principal)	MDS 3.0	1-2 (1 principal; 2 sub either/or)	No
Other Treatment: Intravenous (IV) Access	No	No	1-5 (1 principal; 4 sub)	No	

	(Peripheral IV, Midline, Central line, Other)				
	Nutritional Approach: Parenteral/IV Feeding	Yes	MDS 3.0, IRF-PAI, OASIS-C2	1	No
	Nutritional Approach: Feeding Tube	No	MDS 3.0, OASIS-C2	1	No
	Nutritional Approach: Mechanically Altered Diet	No	MDS 3.0, IRF-PAI, OASIS-C2	1	No
	Nutritional Approach: Therapeutic Diet	No	MDS 3.0	1	No
Medical Condition & Comorbidity	Percent of Resident or Patients with Pressure Ulcers that are New or Worsened	Yes	n/a	1	No, but required for FY 2019
	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	Yes	n/a	1	Yes
Impairment	Hearing	No	MDS 3.0, OASIS-C2	1	No
	Vision	No	MDS 3.0, OASIS-C2	1	No

LTCH QRP Public Reporting

CMS finalized its proposal to publicly report data in CY 2018 for three assessment-based measures for which data collection began on April 1, 2016. The measures that will have data publicly reported include:

- Percent of LTCH Patients With an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function
- Application of Percent of LTCH Patients With an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function
- Application of Percent of Residents Experiencing One or More Falls with Major Injury.

In addition, CMS finalized its proposal to publicly report data in CY 2020 for the assessment-based measure Functional Outcome Measure: Change in Mobility Among Patients Requiring Ventilator Support. Pending availability, data will be displayed based on four rolling quarters of information, initially using discharges from Jan. 1, 2017 through Dec. 31, 2017 (with the exception of the Functional Outcome Measure, which will be based on rolling quarters of data and will initially use discharges from Jan. 1, 2017 through Dec. 31, 2018).

CMS will assign LTCHs with fewer than 20 eligible cases during a performance period to a separate category labeled “the number of cases/patient stays is too small to report.” If an LTCH is in this category, the performance will not be publicly reported for the measure for that performance period.

In addition, CMS will publicly report three claims-based measures adopted in the FY 2017 IPPS/LTCH final rule. The measures are:

- Medicare Spending Per Beneficiary (MSPB)
- Discharge to Community
- Potentially Preventable 30-Day Post Discharge Readmission

While the confidential feedback reports for these measures will be based on CY 2015 and 2016 and data collected for discharges from Jan. 1, 2015 through Dec. 31, 2016, CMS revises the dates for public reporting. CMS will transition from calendar year to fiscal year to make these measure data publicly available by October 2018.

CMS will assign LTCHs with fewer than 25 eligible cases (or fewer than 20 for the MSPB measure) during a performance period to a separate category labeled “the number of cases/patient stays is too small to report.” If an LTCH is in this category, the performance will not be publicly reported for the measure for that performance period.

Removal of Items from LTCH CARE Data Set

CMS will remove the program interruption items from the LCDS effective July 1, 2018. These items include:

- A2500, Program Interruption(s)
- A2510, Number of Program Interruptions During This Stay in This Facility
- A2525, Program Interruption Dates

NEXT STEPS

On Tuesday, Aug. 29, 3 p.m. ET, the AHA will host a member conference call to discuss and collect feedback on this final rule. To register for this call, click [here](#). Related materials and a recording of this call will be available at www.aha.org/postacute in the LTCH section.

For questions regarding the rule’s payment provisions, contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org. For questions regarding quality-related provisions, contact Caitlin Gillooley, associate director of policy, at cgillooley@aha.org.