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Regulatory Advisory

August 26, 2021

Long-term Care Hospital PPS Final Rule for FY 2022

At A Glance

At Issue

On Aug. 2, the Centers for Medicare & Medicaid Services (CMS) issued its fiscal year (FY) 2022 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 issued a separate advisory on the inpatient PPS provisions.

Key Takeaways

The final rule:

- Increases net LTCH payments by 1.1% ($42 million) in FY 2022.
- Calculates FY 2022 payments using data from FY 2019, instead of FY 2020.
- Expands the LTCH Quality Reporting Program to assess the rate of COVID-19 vaccination among health care personnel.

Our Take

The AHA appreciates that the agency took a relatively streamlined approach to the LTAC provisions in this rule. This will help LTCH facilities focus on their COVID-19 responses and not on modifying operations to comply with substantial changes in policy. This is particularly important given recent surges of the virus, as well as AHA's analysis that found that in December 2020, 1 out of 2 LTCH patients had or were recovering from the virus. In addition, we note that since LTCH site-neutral cases are no longer being paid a blended rate, some LTCHs continue to struggle with the Medicare payment amount. Specifically, Medicare on average continues to underpay materially for this population of cases, as AHA has shared with CMS and other policymakers on many occasions. With regard to quality, while AHA suggested an incremental — rather than immediate — implementation of the COVID-19 vaccination-among-health care personnel (HCP) measure, we plan to work with our members and CMS to gather this important data without unnecessarily increasing burdens on providers.

What You Can Do

- ✓ Share the attached summary with your senior management team to examine the impact these changes, which are generally effective Oct. 1, will have on your organization in FY 2022.
- ✓ As an additional resource, refer to the recording and materials for the Aug. 10 member call that AHA hosted on this and the other FY 2022 final rules for post-acute care.

Further Questions

Please contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org for questions on payment provisions, and Caitlin Gillooley, senior associate director of policy, at cgillooley@aha.org for quality-related questions.

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Final LTCH PPS Standard Rate Update

The rule reports that in FY 2020, the proportion of LTCH cases in the standard-rate category was 75% — the same as the previous year.

Final FY 2022 Standard Rate

The rule includes the statutorily mandated market-basket update of 2.6%, which will be offset by a statutorily mandated cut of 0.7% for productivity, as well as a cut for high-cost outlier payments, which is discussed below. For LTCHs reporting required quality data, the standard rate in FY 2022 increases from the current rate of $43,755.34 to $44,713.67. This amount reflects a budget neutrality adjustment to the final standard rate to account for the area wage index.

Medicare-severity Long-term Care Diagnosis-related Group (MS-LTC-DRG) Weights

For FY 2022, CMS calculates the MS-LTC-DRG relative weights using the same methodology as prior years while utilizing the March 2020 update of the FY 2019 Medicare Provider Analysis and Review (MedPAR) file and also excluding site-neutral eligible cases from the recalibration. The rule's online addendum lists the final MS-LTC-DRGs and the respective relative weights, average length of stay and geometric mean length of stay (used to identify short-stay outliers).

Labor-related Share and Area Wage Index

The labor-related share is the portion of total LTCH costs related to, influenced by or varied by local labor market; such costs include wages, salaries and benefits. The rule finalized a FY 2022 labor-related share of 67.9%, based on the agency's projected FY 2022 market basket update. The labor-related share is implemented in a budget-neutral manner to avoid any change to aggregate LTCH PPS payments. The LTCH PPS will continue to use the inpatient PPS' pre-reclassification, unadjusted wage indexes.

High-cost Outliers (HCOs)

For LTCH PPS HCOs in FY 2022, CMS finalized an increased fixed-loss amount of $33,015, which reduces the number of cases that qualify for HCO payments. We note that the 21st Century Cures Act of 2016 lowered the HCO pool from 8% to 7.975%. This reduction in outlier payments for FY 2022, which is intended to maintain total HCO payments within this mandated cap, creates a 0.8% offset to the market basket for the upcoming FY.

In order to account for the impact of the COVID-19 public health emergency (PHE), CMS adjusts its methodology for calculating the FY 2022 fixed-loss amount. Specifically, CMS implements "technical changes" to its methodology for calculating both the inflation factor it applies to charges on MedPAR claims, as well as its determination of cost-to-charge ratios (CCRs), which are used to identify the fixed-loss amount for each LTCH.

Use of a Charge Inflation Factor. Due to a significant difference between estimated and actual charge inflation for FY 2020, a result of the impact of the COVID-19 PHE, CMS finalized as proposed a charge inflation factor based on the historical growth in charges from the prior two

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years. Specifically, CMS uses the March 2020 update of the FY 2019 MedPAR file and the March 2019 update of the FY 2018 MedPAR file. Previously, the charge inflation factor was based on estimates calculated from quarterly market basket update values determined by the CMS Actuary. The national charge inflation factor is calculated by dividing the national average charge from the FY 2019 file by the average charge based on the FY 2018 file. CMS then inflates the billed charges obtained from the FY 2019 MedPAR file using the three-year charge inflation factor that results from these calculations to determine the fixed-loss amount for FY 2022.

Final CCRs. Historically, CMS used CCRs based on the most recently available provider specific file (PSF) without any adjustment. For FY 2022, as proposed, CMS will adjust CCRs used to calculate the fixed-loss amount by a factor that is based on historical changes, which results from dividing an LTCH's case-weighted CCR from the most recent PSF by that from the prior year PSF. Specifically, to avoid PHE data concerns for the FY 2022 calculation, CMS uses the March 2020 and March 2019 PSFs, along with claims from the March 2020 update of the FY 2019 MedPAR file. For LTCHs that have relied on a statewide average CCRs in the past, CMS multiplied their CCR from the March 2020 PSF by the two-year national CCR adjustment factor that resulted from these calculations.

LTCH Site-neutral Payment Rates

For FY 2022, as proposed, CMS increases LTCH site-neutral payments by 3% (or $11 million) compared to FY 2021. This increase follows the substantial drop last year that was caused by the end of blended rates for this category of LTCH cases. The rule states that the proportion of LTCH cases in the site-neutral category was 25% in FY 2020.

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

- Have a principal LTCH diagnosis related to a psychiatric or rehabilitation condition;
- 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* have a qualifying procedure code for 96 or more 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. Initially, as required by law, site-neutral cases were paid a 50-50 blend of LTCH PPS and site-neutral rates. However, starting with cost reporting periods beginning in FY 2021, all site-neutral cases are paid the full site-neutral rate. Under the law, the cost of the reporting periods starting in FYs 2018 and 2019 are still being offset by a 4.6% cut in effect for FYs 2018 through 2026 market-basket updates for site-neutral cases. This offset is explained in CMS Transmittal 4046.

Note that under relief provided by the Coronavirus Aid, Relief and Economic Security Act of 2020, for the duration of the COVID-19 PHE, all site-neutral cases are being paid a traditional LTCH PPS standard rate.

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High-cost Outliers (HCOs)

For site-neutral cases that are HCOs, CMS continues using the inpatient PPS fixed loss amount. For FY 2022, a $30,988 threshold was finalized.

Budget Neutrality Adjustments (BNAs)

CMS continues applying a 5.1% budget neutrality adjustment to the base portion of site-neutral payments, while exempting the HCO portion of the overall site-neutral payment from this adjustment. The agency states that this BNA is necessary to avoid increasing aggregate FY 2020 LTCH PPS payments in comparison to what LTCHs would be paid if the payment system has no site-neutral element. In AHA's view — which has been shared in detail with CMS on multiple occasions — since the inpatient PPS rates that are used to pay site-neutral cases have already been reduced by 5.1% to ensure budget neutrality for inpatient PPS outlier payments, this "second" 5.1% BNA applied within the LTCH framework is redundant and represents a systematic reduction of LTCH site-neutral payments.

LTCH Quality Reporting Program (LTCH QRP)

The ACA 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% reduction to the LTCH's annual market-basket update. See Table 1 for finalized measures.

Table 1: Finalized Measures for the LTCH QRP, FY 2021 – FY 2024

Measure	FY 2021	FY 2022	FY 2023	FY 2024
Central Line-associated Blood Stream Infection (CLABSI)	X	X	X	X
Catheter-associated Urinary Tract Infection (CAUTI)	X	X	X	X
Clostridium Difficile Infection (CDI)	X	X	X	X
Influenza Vaccination Coverage among Health Care Personnel	X	X	X	X
Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	X	X	X	X
Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function	X	X	X	X
Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function	X	X	X	X
Change in Mobility among LTCH Patients Requiring Ventilator Support	X	X	X	X
Medicare Spending per Beneficiary for Post-acute Care LTCH QRP (MSPB – LTCH)	X	X	X	X
Discharge to Community – PAC LTCH	X	X	X	X
Potentially Preventable 30-day Post-discharge Readmission Measure for LTCH QRP	X	X	X	X
Drug Regimen Review Conducted with Follow-up for Identified Issues	X	X	X	X
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	X	X	X	X

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Measure	FY 2021	FY 2022	FY 2023	FY 2024
Compliance with Spontaneous Breathing Trial by Day 2 of Stay	X	X	X	X
Ventilator Liberation Rate	X	X	X	X
Transfer of Health Information to Provider		X	X	X
Transfer for Health Information to Patient		X	X	X
COVID-19 Vaccination Coverage among Healthcare Personnel			X	X

X = Finalized

FY 2022 Measurement Provisions

CMS will adopt one new quality measure and adjust the denominator of another beginning with the FY 2023 LTCH QRP. The agency also finalized its proposals regarding publicly reported data, including those affected by the COVID-19 pandemic and related reporting exemptions.

Adoption of COVID-19 Vaccination among Health Care Personnel (HCP) Measure. CMS will adopt this measure that calculates the percentage of HCP eligible to work in the LTCH for at least one day during the reporting period who received a complete vaccination course. LTCHs will be required to submit data beginning Oct. 1, 2021.

The measure excludes persons with contraindications to the COVID-19 vaccination as described by the US Centers for Disease Control and Prevention (CDC). For the purposes of this measure, "health care personnel" is defined as, regardless of clinical responsibility or patient contact:

- Employees (all persons receiving a direct paycheck from the reporting facility);
- Licensed independent practitioners affiliated with but not directly employed by the reporting facility (including post-residency fellows); and
- Adult students/trainees and volunteers.

Facilities may, but are not required to, include other contract personnel. Detailed specifications for this measure can be found of CDC's website.

To report this data, LTCHs will use the CDC's National Healthcare Safety Network (NHSN) Healthcare Personnel Safety Component submission framework, which facilities currently use to report other COVID-19-related data. HCP and resident COVID-19 vaccination data reporting modules are currently available for voluntary reporting through NHSN. LTCHs will submit data through NHSN for at least one week each month, and the CDC will calculate a summary measure of the data each quarter. If LTCHs submit more than one week of data in a month, CDC will use the most recent week's data to calculate the rate. This rate would be publicly reported on the LTCH *Care Compare* website beginning with the September 2022 refresh "or as soon as technically feasible." Instead of accumulating data over time and displaying average performance on the measure using four rolling quarters of data as proposed, CMS will display just the quarterly rate based on the most recent quarter's data.

The measure, which is being adopted in the QRPs for other post-acute and acute care settings, is not endorsed by the National Quality Forum (NQF). CMS and CDC contend that because the measure is aligned with the Influenza Vaccination Coverage among HCP

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(NQF #0431), which is currently endorsed by NQF and used in the LTCH QRP and underwent some validity testing using NHSN data, it is sufficiently specified for inclusion in the LTCH QRP.

Modification of Transfer of Health Information to the Patient (TOH-Patient) Measure. CMS will exclude residents discharged to home under the care of a home health agency or to a hospice from the denominator of this measure, which was adopted in the FY 2020 LTCH PPS final rule for use beginning with the FY 2022 LTCH QRP. The measure evaluates whether a medication list was transferred to a patient or caregiver upon discharge from a post-acute care facility to a non-PAC setting. A similar measure, Transfer of Health Information to the Provider, assesses whether the medication list was transferred to a subsequent provider if the patient is discharged to another PAC setting. Patients discharged home under the care of a home health agency or to a hospice are included in both measures; to avoid double-counting these patients, CMS will exclude them from the TOH-Patient measure beginning with the FY 2023 LTCH QRP.

Public Reporting for Measures Adopted in FY 2018 Rules. CMS will begin public reporting for two measures: Compliance with Spontaneous Breathing Trial by Day 2 of the LTCH Stay and Ventilator Liberation Rate, beginning with the March 2022 *Care Compare* refresh. The inaugural display of the measures will use data collected in Q3 of 2020 through Q2 of 2021, and then four rolling quarters of data thereafter. These measures were first adopted in the FY 2018 IPPS/LTCH PPS final rule, and data collection began with assessments for patients admitted and discharged on or after July 1, 2018.

Publicly Reported Data Affected by the COVID-19 Pandemic. LTCH quality measures are publicly reported on the *Care Compare* website, which uses four quarters of data for LTCH CARE Data Set (LCDS) assessment-based measures and eight quarters for claims-based measures. However, due to the COVID-19 pandemic, CMS granted exceptions to reporting requirements for the fourth quarter of 2019 and the first two quarters of 2020; the agency also stated that it would not publicly report any LTCH QRP data that might be greatly impacted by these exceptions.

CMS determined that temporarily freezing the data displayed on the *Care Compare* website with the October 2020 refresh values — that is, holding the data constant without subsequent update — would be the best approach. However, these data are becoming increasingly out-of-date and thus less useful for consumers. Therefore, CMS proposes to calculate LTCH QRP measures for the January 2022 refresh using three quarters of data for LCDS assessment-based measures and six quarters for claims-based measures for the January 2022 through July 2023 refreshes. Normal reporting would resume for assessment-based measures for the April 2022 refresh and for claims-based measures for the October 2023 refresh.

Further Questions

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