

FY 2020 LTCH Prospective Payment System Proposed Rule

April 30, 2019

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On April 23, 2019, the Centers for Medicare & Medicaid Services (CMS) issued its fiscal year (FY) 2020 proposed rule for the Long-Term Care Hospital Prospective Payment System (LTCH PPS). The proposed rule will be published in the Federal Register on May 3, 2019 and is currently available online.¹ Comments are due no later than 5 pm ET on June 24, 2019.

In addition to this advisory, we are making available a comparison of the corrected final FY 2019 and proposed FY 2020 MS-LTC-DRG weights. We also are updating hospital-specific impacts and will share those updates with you in the coming weeks. For additional information, please contact Lane Koenig, PhD, Director of Policy and Research at 240-403-0154x301 or lane.koenig@knghealth.com.

Estimated Impact of FY 2020 Proposed Rule on LTCH Payments

In its impact analysis, CMS estimates that the average payment for cases meeting the LTCH patient criteria (referred to in the proposed rule as LTCH PPS Standard Federal Payment Rate cases) will increase by 2.6% from \$47,472 to \$48,561 between FY 2019 and FY 2020 (assuming no change in case mix). In FY 2018, approximately 71% of all LTCH cases met the new patient criteria. CMS estimates that payments for cases meeting the LTCH patient criteria will increase by roughly \$79 million (~2.3%). Payments made for cases that do not meet LTCH patient criteria (~29%), are estimated to fall by approximately \$41 million (~4.9%). Overall, CMS projects LTCH payments to increase by \$37 million (~0.9%). The estimates reported by CMS in the proposed rule do not include payment reductions due to sequestration.

Patient Criteria and Payment Policies

In the Pathway for Sustainable Growth Rate Reform Act of 2013, Congress established patient-specific criteria for a case to be eligible to receive full payment under the LTCH PPS. For all other cases, LTCHs receive a “site-neutral” amount, which is the lower of the LTCH’s cost for the case or an IPPS-comparable per diem payment. The legislation called for full implementation of the site-neutral payment policy beginning with discharges in LTCHs’ cost reporting periods starting on or after October 1, 2017, with transitional blended payments (50% LTCH PPS and 50% full site-neutral payment) in LTCHs’ 2016 and 2017 cost reporting periods. However, Section 51005 of the Bipartisan Budget Act of 2018 extended the transitional blended payment rate period for site-neutral payment rate cases for two years. As a result, LTCHs will start to receive full site-neutral payments for discharges occurring in their FY 2020 cost reporting periods. To pay for the extension of the transitional blended payment, Congress directed CMS to reduce the IPPS-comparable per diem payment for site-neutral cases by 4.6% for discharges starting in FY 2018 (i.e., October 1, 2018) through FY 2026. The projected reduction in payments to site-neutral cases in FY 2020 (~4.9% reduction) reflects the phasing out of the transitional blended payments.

¹ <https://www.federalregister.gov/d/2019-08330>

In Table 1, we summarize key elements of the proposed rule related to its implementation of the LTCH patient criteria and associated payment policies. We note that CMS is proposing no new policy changes for FY 2020 other than regular payment updates.

Table 1. Proposed Payment Policies for Full LTCH PPS and Site-Neutral Cases

	Eligible for Full LTCH PPS	Site-Neutral Cases
LTCH Patient Criteria	To receive the full payment under LTCH PPS, a patient must be discharged from a subsection(d) hospital on the same day or one day before LTCH admission, be discharged from the LTCH with a principal diagnosis OTHER than for a psychiatric disorder or rehabilitation, and meet either the ICU or Ventilator criteria.	
ICU Patient Criterion	Spent 3+ days in an intensive care unit (ICU) during the immediately preceding subsection(d) hospital stay. ICU determination is based on revenue center codes 020x and 021x.	Fewer than 3 days in an ICU.
Ventilator Criterion	Received 96+ hours of continuous invasive mechanical ventilation in LTCH, as identified by ICD-10-PCS 5A1955Z.	No ICD-10-PCS code of 5A1955Z on LTCH claim.
Psychiatric or Rehabilitation	MS-LTC-DRG not related to psychiatric disorders or rehabilitation.	Patient grouped to MS-LTC-DRG 876, 880-887, 894-897, or 945-946.
Base Payment	For hospitals submitting quality information, the standardized amount updated by 2.7%, but adjusted downward for the 25% Rule and wage index budget neutrality adjustments.	Lower of 100% of LTCH cost or IPPS comparable amount. IPPS standardized amount updated by 2.7% , multiplied by HCO budget neutrality factor of 0.949 (base payment only) and adjustment to account for extension of transitional blended payment of 0.954.
High-Cost Outlier (HCO)	Proposed HCO fixed-loss amount of \$29,997, up from \$27,121 in FY 2019.	Use the IPPS HCO fixed-loss amount (\$26,994, up from \$25,743 in FY 2019). Site-neutral cases paid on a cost basis are not eligible for outlier payments.
Short-Stay Outlier (SSO)	Cases with LOS <= 5/6 geometric mean paid IPPS comparable LTCH blend.	SSO policy does not apply.
25% Rule	Elimination of the 25% Rule in FY 2019 rule. In FY 2020, budget neutrality adjustment applied to standardized rate to pay for the change.	

Update to the LTCH PPS Standardized Amount and Other Routine Policy Changes

For hospitals meeting the requirements of the Long-Term Care Hospital Quality Reporting Program (LTCH QRP), the proposed FY 2020 LTCH standard payment rate will increase by \$1,392.23 from \$41,558.68 to \$42,950.91. This rate is only applicable for cases meeting the LTCH patient criteria. The update is based on five factors:

1. Market basket update (MB)
2. Adjustment to account for multifactor productivity increases (MFP)
3. Penalty for hospitals failing to meet quality reporting requirements (QRP)
4. Budget neutrality adjustment associated with wage index changes (Wage Index)
5. Budget neutrality adjustment associated with elimination of the 25% Rule (25% Rule)

The application of these adjustment factors and the derivation of the proposed FY 2020 standard payment rate are shown in Figure 1.

Figure 1. Calculation of the FY 2020 Standard LTCH Payment Rate

Meet QRP → $\$41,558.68 \times (1.032 - 0.005 - 0.00) \times 1.0064747 \times 0.999856 = \$42,950.91$

Failed QRP → $\$41,558.68 \times (1.032 - 0.005 - 0.02) \times 1.0064747 \times 0.999856 = \$42,114.47$

FY 2019 Rate	MB	MFP	QRP	Wage Index	25% Rule	FY 2020 Rate
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There are several additional policy updates discussed in the proposed rule. They are:

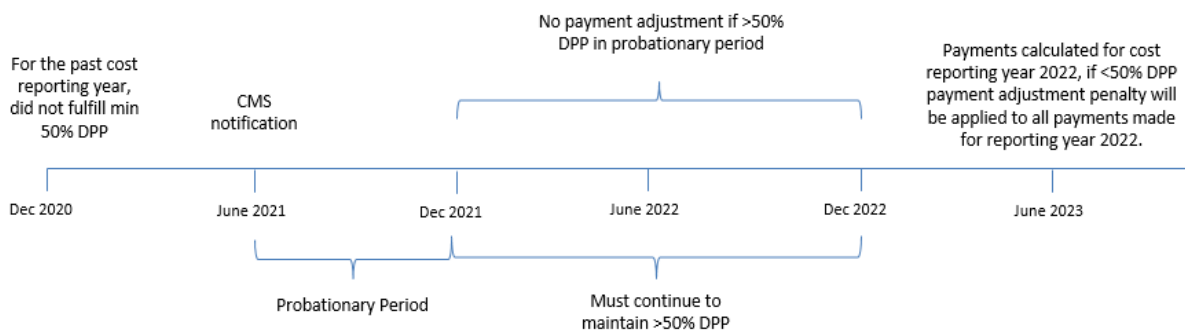
- The proposed labor portion of the standard amount is 66%.
- Proposed updates to the relative weights for MS-LTC-DRGs are presented in a separate Excel worksheet.
 - The MS-LTC-DRG weights were developed using only cases that would meet the LTCH criteria and, therefore, would qualify for full LTCH PPS payment.
- The proposed High-Cost Outlier (HCO) fixed-loss amounts
 - Fixed-loss amount for full LTCH PPS cases: \$29,997 (up from \$27,121 in FY 2019)
 - Fixed-loss amount for site-neutral cases (equal to IPPS fixed-loss amount): \$26,994 (up from \$25,743)

Implementation of 50% Standard Rate Case Requirement and Associated Process

CMS is proposing a process to implement the requirement that an LTCH have an “LTCH discharge payment percentage” of at least 50% beginning with discharges in cost reports starting on or after October 1, 2019. The LTCH discharge payment percentage is the ratio of an LTCH’s Medicare discharges that qualify for the standard Federal payment rate to the total number of Medicare Fee-for-Service discharges paid under the LTCH PPS during an LTCH’s cost reporting period.

Since LTCH discharge payment percentages can only be calculated after a cost reporting period has ended, CMS typically informs an LTCH of its official discharge payment percentage 5 to 6 months after the end of the LTCH’s cost reporting period. If an LTCH is found to have a discharge payment percentage under 50%, the LTCH would be subject to a payment adjustment in the subsequent cost reporting period. This payment adjustment subjects the LTCH that fails to meet the 50% requirement to a payment amount comparable to the IPPS discharge payment amount, with an additional payment for high-cost outlier cases based on the IPPS fixed-loss amount, for all its cases. For example, an LTCH whose cost reporting period for FY 2020 is January 1, 2020 to December 31, 2020 would be notified of its failure to meet the requirement in May or June of 2021. Thus, the next cost reporting period for which the payment penalty would apply would be for discharges on or after the start in the next cost reporting period following the notification – that is, January 1, 2022.

CMS is proposing a special probationary reinstatement process (probationary-cure period), which would allow an LTCH the ability to have the payment adjustment delayed. During this probationary-cure period (six months immediately preceding the cost reporting period in which the IPPS payment adjustment would apply), if an LTCH met the 50% required DPP for at least five consecutive months, they would no longer be subject to the payment adjustment for that following cost reporting period. CMS would then assess whether an LTCH met the 50% requirement for the cost reporting period and, if not, it would recover payment for the cost reporting through a reconciliation process. If, however, the LTCH did meet the requirement, no additional reconciliation would be made. If finalized as proposed, CMS expects to issue guidance to describe the specific procedures for implementing the proposed probationary-cure period policy. An example of a probationary reinstatement process timeline for an LTCH that follows a calendar year scheduled fiscal year is below.



Quality Measures and Standardized Patient Assessment Data

To receive the full annual update for a payment year, LTCHs must submit data on quality measures or else receive a 2-percentage-point reduction. The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 enacted new data reporting requirements for LTCHs and other PAC providers on quality measures in five domains, data reporting requirements on resource use and other measures in three domains, and data reporting requirements on assessment in five categories. The Secretary may specify other categories as deemed necessary and appropriate.

In the FY 2018 LTCH PPS proposed rule, CMS proposed to adopt standardized patient assessment data elements (SPADEs) that would satisfy requirements in the IMPACT Act. Commenters expressed concern that CMS was moving too quickly to adopt SPADEs and modify the assessment instruments while other requirements were being adopted under the IMPACT Act at the same time. In response to public comments, CMS decided to adopt two existing quality measures in the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS) as SPADEs with respect to two of the five categories (functional status and medical conditions and comorbidities) in the FY 2018 final rule and engaged a contractor (RAND) to do further testing on the other elements.

Specifications for the quality measures and standardized patient assessment data elements as proposed in the FY 2020 LTCH PPS Proposed Rule are located 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>.

Quality Measures Proposed for Adoption for Fiscal Year 2022 LTCH Quality Reporting Program and Subsequent Years

CMS is proposing to adopt two quality measures for the FY 2022 LTCH Quality Reporting Program (QRP). CMS believes these measures will satisfy the requirement in the IMPACT Act to adopt a quality measure in the Transfer of Health Information domain. The data collection will begin with discharges beginning October 1, 2020.

Beginning with the FY 2022 LTCH QRP, CMS is proposing to adopt the following two measures:

- **Transfer of Health Information to the Provider – Post-Acute Care** – assesses whether or not a current reconciled medication list is given to the subsequent provider when a patient is discharged or transferred from his/her current PAC setting. Data for the proposed quality measure would be calculated using data from the LCDS.
- **Transfer of Health Information to the Patients – Post-Acute Care** – assesses whether or not a current reconciled medication list was provided to the patient, family, or caregiver when the patient was discharge from a PAC setting to a private home/apartment, a board and care home, assisted living, a group home, transitional living or home under care of an organized home health

service organization, or a hospice. Data for the proposed quality measure would be calculated using data from the LCDS.

Beginning with the FY 2020 LTCH QRP, CMS is proposing to modify the following measure:

- **Discharge to Community** – exclude baseline nursing facility residents who already reside in the nursing facility prior to the LTCH stay in the FY 2020 LTCH QRP. These residents will be defined as LTCH patients who had a long-term nursing facility stay in the 180 days preceding their hospitalization and LTCH stay, with no intervening community discharge between the nursing facility stay and hospitalization.

CMS assessed the impact of excluding baseline nursing facility residents using calendar year (CY) 2015 and CY 2016 data. After the exclusion was applied, baseline nursing facility residents comprised of 9.2% of the measure population. The observed patient-level discharge to community rates were significantly lower for baseline nursing facility residents (1.4%) compared with non-nursing facility residents (23.9%). About forty percent of LTCHs observed an increase in their risk-standardized discharge to community rate that exceeded the national observed patient-level discharge to community rate (23.9%).

Quality Measures for FY 2021 Payment Determinations and Subsequent Years

In Table 2, we present the measures that are currently adopted for the FY 2021 LTCH QRP. Measures highlighted in grey will be introduced in FY 2022 LTCH QRP.

Table 2. Quality Measures Currently Adopted for FY 2021 LTCH QRP

NQF Measure ID	Measure Title
LTCH CARE Data Set	
NQF #0674	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
NQF #2631	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	Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
NQF #2632	Functional Outcome Measure: Change in Mobility Among Long-Term Care Hospital Patients Requiring Ventilator Support
Not NQF Endorsed	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
Not NQF Endorsed	Compliance with Spontaneous Breathing Trial (SBT) by Day 2 of the LTCH Stay
Not NQF Endorsed	Drug Regimen Review Conducted with Follow-Up for Identified Issues – Post Acute Care Long-Term Care Hospital Quality Reporting Program

NQF Measure ID	Measure Title
Not NQF Endorsed	Transfer of Health Information to the Patients – Post-Acute Care
Not NQF Endorsed	Transfer of Health Information to the Provider – Post-Acute Care
Not NQF Endorsed	Ventilator Liberation Rate
National Healthcare Safety Network (NHSN)	
NQF #0138	National Healthcare Safety Network Catheter-Associated Urinary Tract Infection (NHSN CAUTI) Outcome Measure
NQF #0139	National Healthcare Safety Network Central Line-Associated Bloodstream Infection (NHSN CLABSI) Outcome Measure
NQF #0431	Influenza Vaccination Coverage among Healthcare Personnel
NQF #1717	National Healthcare Safety Network Facility-wide Inpatient Hospital-onset <i>Clostridium difficile</i> Infection (NHSN CDI) Outcome Measure
Claims-Based	
Not NQF Endorsed	Medicare Spending Per Beneficiary – Post Acute Care Long-Term Care Hospital Quality Reporting Program
Not NQF Endorsed	Discharge to Community - Post Acute Care Long- Term Care Hospital Quality Reporting Program
Not NQF Endorsed	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Long-Term Care Hospital Quality Reporting Program

Proposed Standardized Patient Assessment Data Reporting for the LTCH QRP

Since the FY 2018 LTCH PPS final rule, CMS has conducted further testing of additional SPADEs and believes that the testing supports the use of these additional elements in the PAC assessment instruments. CMS also believes that LTCHs have had an opportunity to familiarize themselves with other new reporting requirements adopted under the IMPACT Act. CMS is proposing to adopt many of the same SPADEs previously proposed for adoption, along with other SPADEs for the FY 2022 LTCH QRP. The Secretary is also proposing a new category, social determinants of health, under his authority set in the IMPACT Act to adjust the quality and patient assessment data to account for studies conducted by Assistant Secretary of Health and Human Services for Planning and Evaluation (ASPE) on social risk factors and other information and individual's health status and other factors. CMS is proposing to collect data for seven data elements under the social determinants of health category.

In selecting the proposed SPADEs, CMS considered the burden of assessment-based data collection and aimed to minimize the additional burden by evaluating whether any data that is currently collected through one or more PAC assessment instruments could be collected as SPADEs. In selecting the proposed SPADEs, CMS also took into consideration the following factors with respect to each data

element: (1) Overall clinical relevance; (2) Interoperable exchange to facilitate care coordination during transitions in care; (3) Ability to capture medical complexity and risk factors that can inform both payment and quality; and (4) Scientific reliability and validity and general consensus agreement for its usability. CMS also drew input from a variety of sources, including feedback from clinical and technical experts, results from the Post-Acute Care Payment Reform Demonstration and SPADE National Beta Testing, and Special Open Door Forums.

If finalized as proposed, LTCHs would be required to report these data with respect to LTCH admissions and discharges that occur between October 1, 2020 and December 31, 2020 for the FY 2022 LTCH QRP. Beginning with the FY 2023 LTCH QRP, CMS is proposing that LTCHs must report data with respect to admissions and discharges that occur during the subsequent calendar year (for example, CY 2021 for the FY 2023 LTCH QRP, CY 2022 for the FY 2024 LTCH QRP). CMS is also proposing that the data LTCHs submit for the Hearing, Vision, Race and Ethnicity SPADEs at admission be considered to also have been submitted at discharge as well, because it is unlikely that the assessment of those SPADEs at admission will differ from discharge. Table 3 lists the proposed standardized patient data by category.

Table 3. Proposed Data Elements for Standardized Patient Assessment Data

Category	Data Elements
Functional Status	<i>Functional Status</i> – Consists of 6 data elements that assesses mobility. The proposed functional status data elements have been adopted into the HH, IRF, and SNF under their respective patient/resident assessment instruments. The data elements will need to be added to the LCDS.
Cognitive Function and Mental Status	<i>Brief Interview of Mental Status (BIMS)</i> – Consists of 7 questions that create a cognitive function score. The data elements will need to be added to the LCDS.
	<i>Confusion Assessment Method (CAM)</i> – Consists of questions that screens for overall cognitive impairment and distinguishes delirium or reversible confusion from other types of cognitive impairment. CMS is proposing to replace the current version of the CAM used in the LCDS with the four-item version of the CAM currently used in the Minimum Data Set (MDS) for SNFs.
	<i>Patient Health Questionnaire - 2 to 9 (PHQ-2 to 9)</i> – Consists of 2 questions that assess for depressed mood and anhedonia (inability to feel pleasure) and the PHQ-9 mood interview, which assesses presence and frequency of the nine cardinal symptoms of depression. The data elements will need to be added to the LCDS.
Special Services, Treatments and Interventions	<i>Cancer Treatment Chemotherapy (IV, Oral, Other)</i> – Consists of the principal Chemotherapy data element and three sub elements: IV Chemotherapy, Oral Chemotherapy, and Other. The third category captures other less common chemotherapeutic approaches. The data elements will need to be added to the LCDS.
	<i>Cancer Treatment: Radiation</i> – Consists of 1 question assessing whether a patient is receiving radiation. The data element will need to be added to the LCDS.

Category	Data Elements
	<i>Respiratory Treatment: Oxygen Treatment (Continuous, Intermittent, High-Concentration Oxygen Delivery System)</i> – Consists of the principal Oxygen data element and three sub-elements, “Continuous” (whether the oxygen was delivered continuously, typically defined as ≥ 14 hours per day), “Intermittent,” or “High-concentration oxygen delivery system.” The data elements will need to be added to the LCDS.
	<i>Respiratory Treatment: Suctioning (Scheduled, As needed)</i> – Consists of the principal Suctioning data element and two sub-elements, “Scheduled” (suctioning based on a specific frequency) and “As needed” (suctioning only when indicated). The data elements will need to be added to the LCDS.
	<i>Respiratory Treatment: Tracheostomy Care</i> – Consists of 1 question assessing tracheostomy care. The data element for Tracheostomy Care will need to be added to the LCDS.
	<i>Respiratory Treatment: Non-invasive Mechanical Ventilator (Bilevel Positive Airway Pressure (BiPAP), Continuous Positive Airway Pressure (CPAP))</i> – Consists of the principal Non-invasive Mechanical Ventilator data element and two sub-elements, BiPAP and CPAP. The existing data elements for “Non-invasive Ventilator (BiPAP, CPAP)” will be retained in the LCDS, the main data element will be renamed to Non-invasive Mechanical Ventilator, and two sub-elements for BiPAP and CPAP will be added.
	<i>Respiratory Treatment: Invasive Mechanical Ventilator</i> – Consists of 1 question that will be collected at admission from the existing Invasive Mechanical Ventilator Support upon Admission to LTCH data element and will be added as a new data element at discharge in the LCDS.
	<i>Intravenous (IV) Medications (Antibiotic, Anticoagulation, Vasoactive Medications, Other)</i> – Consists of the principal IV Medications data element and four sub-elements: Antibiotics, Anticoagulations, Vasoactive Medications, and Other. The data elements will need to be added to the LCDS.
	<i>Transfusions</i> – Consists of 1 question that assesses whether the patient received transfusions. The MDS version of the data element currently used by SNFs will need to be added to the LCDS.
	<i>Dialysis (Hemodialysis, Peritoneal dialysis)</i> – Consists of the principal Dialysis data element and two sub-elements, Hemodialysis and Peritoneal dialysis. The existing Dialysis data element in the LCDS will need to be expanded to include sub-elements for Hemodialysis and Peritoneal dialysis.
	<i>Intravenous (IV) Access (Peripheral IV, Midline, Central line)</i> – Consists of the principal IV Access data element and three sub-elements, Peripheral IV, Midline, and Central line. The data elements will need to be added to the LCDS.
	<i>Nutritional Approach: Parenteral/IV Feeding</i> – Consists of a single question that assesses parenteral feeding/IV feeding. The existing Total Parenteral Nutrition data element in the LCDS will need to be replaced with the Parenteral/IV Feeding data element.
	<i>Nutritional Approach: Feeding Tube</i> – Consists of a single question assessing the use of a feeding tube. The data element will need to be added to the LCDS.

ADVISORY

Category	Data Elements
	<i>Nutritional Approach: Mechanically Altered Diet</i> – Consists of a single question on use of a Mechanically Altered Diet. The data element will need to be added to the LCDS.
	<i>Nutritional Approach: Therapeutic Diet</i> – Consists of a single question on use of a Therapeutic Diet. The data element will need to be added to the LCDS.
	<i>High-Risk Drug Classes: Use and Indication</i> – Consists of one High-Risk Drug class data element with six medication classes as sub-elements. The six data response options are Anticoagulants, Antiplatelets, Hypoglycemics, Opioids, Antipsychotics, and Antibiotics. The data elements will need to be added to the LCDS.
Medical Condition and Comorbidity	<i>Pain Interference (Pain Effect on Sleep, Pain Interference with Therapy Activities, and Pain Interference with Day-to-Day Activities)</i> – Consists of three data elements: Pain Effect on Sleep (frequency with which pain effects a patient's sleep), Pain Interference with Therapy Activities (frequency with which pain interferes with a patient's ability to participate in therapies), and Pain Interference with Day-to-Day Activities (the extent to which pain interferes with a patient's ability to participate in day-to-day activities excluding therapy). The data elements will need to be added to the LCDS.
Impairment Data	<i>Hearing</i> – Consists of 1 question that assesses level of hearing impairment. The MDS version of the Hearing data element will need to be added to the LCDS.
	<i>Vision</i> – Consists of 1 question that assesses level of vision impairment with five response categories. The MDS version of the Vision data element will need to be added to the LCDS.
Social Determinants of Health	<i>Race and Ethnicity</i> – Consists of two questions with fourteen response options for the Race data element and five response options for the Ethnicity data element. The current Race and Ethnicity data element will need to be revised in the LCDS.
	<i>Preferred Language and Interpreter Services</i> – Consists of two data elements with an open-ended response for the Preferred Language data elements and two response options for the Interpreter Services data elements. The data elements are currently in use in the LCDS.
	<i>Health Literacy</i> – Consists of one data element that assess reading ability with five response options. The data element will need to be added to the LCDS.
	<i>Transportation</i> – Consists of one data element with three response options that assesses access to transportation. The data element will need to be added to the LCDS.
	<i>Social Isolation</i> – Consists of one data element with five response options that will assess social isolation. The data element will need to be added to the LCDS.

Future Measures and Measure Concepts under Consideration for the LTCH QRP

CMS is inviting public comments on the importance, relevance, appropriateness, and applicability for the quality measures, standardized patient assessment data elements, and concepts for future consideration listed in Table 3.

Table 3. Future Measures, Standardized Patient Assessment Data Elements, and Concepts under Consideration for the LTCH QRP

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

Data Collection

CMS has migrated to a new internet Quality Improvement and Evaluation System (iQIES) for LTCHs to submit assessment data for the LCDs. CMS is proposing to designate the system as the data submission system for the LTCH QRP beginning October 1, 2019. CMS is proposing to notify the public of any future changes to the iQIES using subregulatory mechanisms, such as website postings, listserv messaging, and webinars.

CMS is proposing that the implementation of future versions of the LTCH CARE Data Set be moved from April to October, beginning October 1, 2020 to provide LTCHs with an additional 6 months to prepare for any changes to the reporting requirements.

For the initial year in which quality measures or standardized patient assessment data are adopted, CMS is proposing that 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. In following program years, LTCHs would be required to report data on patients who are admitted and discharged in the 12-month calendar year that applies to the program year. Table 4

provides an example of the proposed data collection period for FY 2022 and FY 2023 LTCH QRP that applies to all measures and standardized patient assessment data except the Influenza Vaccination Coverage Among Healthcare Personnel measure data, which is submitted annually.

Table 4. Reporting Period for Quality Measures* and Standardized Patient Assessment Data Reporting for the FY 2022 and FY 2023 LTCH QRP**

Proposed Data Collection Quarterly Reporting Period	Proposed Data Submission Quarter Deadlines
CY 2020 Q4: 10/1/2020-12/31/2020***	CY 2020 Q4 Deadline: May 15, 2021
CY 2021 Q1: 1/1/2021-3/31/2021	CY 2021 Q1 Deadline: August 15, 2021
CY 2021 Q2: 4/1/2021-6/30/2021	CY 2021 Q2 Deadline: November 15, 2021
CY 2021 Q3: 7/1/2021-9/30/2021	CY 2021 Q3 Deadline: February 15, 2022
CY 2021 Q4: 10/1/2021-12/31/2021	CY 2021 Q4 Deadline: May 15, 2022

*The submission deadline for the Influenza Vaccination Coverage Among Healthcare Personnel measure is annual, not quarterly. The proposed data collection reporting period for the Influenza Vaccination Coverage Among Healthcare Personnel measure for the FY 2022 LTCH QRP is 10/1/2020-3/31/2021 and its proposed deadline is May 15, 2021. The proposed data collection reporting period for the Influenza Vaccination Coverage Among Healthcare Personnel measure for the FY 2023 LTCH QRP is 10/1/2021-3/31/2022 and its proposed deadline is May 15, 2022.

**Applies to data reporting using the LTCH CARE Data Set and NHSN.

***Initial Reporting Period for Quality Measures and Standardized Patient Assessment Data for FY 2022 LTCH QRP

Public Display of Quality Measure Data and Compliance List for the LTCH QRP

CMS is proposing to begin publicly displaying data on the LTCH Compare website for the Drug Regimen Review Conducted with Follow-Up for Identified Issues beginning in CY 2020 or as soon as technically feasible. The displaying data will be based on four rolling quarters, initially using discharges from January 1, 2019 through December 31, 2019 (Quarter 1 2019 through Quarter 4 2019). CMS will not display the data on the measure if an LTCH had fewer than 20 eligible cases in any four consecutive rolling quarters.

In addition, CMS is proposing to no longer publish a list of compliant LTCHs who successfully met the reporting requirements for the applicable payment determination on the LTCH QRP website, effective FY 2020 payment determination.