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FY18 Proposed Changes to the Long-Term Care Hospital (LTCH) Prospective Payment System

SUMMARY

Table of Contents

I. Proposed Changes to the Long-Term Care Hospital Prospective Payment System (LTCH PPS) for FY 2018

A. Background

Significant changes to the LTCH PPS, as mandated by Section 1206 of Pathway for SGR Reform Act (Pub.L.113-67), were implemented starting in FY 2016, establishing a dual-rate payment structure. For FY 2018, CMS again applies the term "LTCH PPS standard federal payment rate case" when the criteria for site neutral payment rate exclusion are met and applies the term "site neutral payment rate case" to any LTCH PPS case 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 2018:

- Case cannot have a principal diagnosis (DRG) 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 qualify for exclusion from the site neutral payment rate, 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. The 21st Century Cures Act also contained several provisions that affect the LTCH PPS. Key changes proposed for FY 2018 include actions by CMS to:

- Modify the payment methodology for high-cost outlier payments made to LTCHs.
- Extend various moratoria on the implementation of the 25-percent payment adjustment threshold.
- Revise the requirements of the average length-of-stay criterion for LTCH classification.
- Implement a temporary exception to the site neutral payment rate for certain spinal cord hospitals and for certain wound care discharges.
- Modify the short-stay outlier adjustment policy.

Summary of Proposed Changes to LTCH PPS Rates for FY 2018*	
Standard Federal Rate, FY 2017	$42,476.41
Proposed rule update factors	
Update as required by Section 1886(m)(3)(C) of the Act	+1.0%
Penalty for hospitals not reporting quality data	-2.0%
Net update, LTCHs reporting quality data	+1.0% (1.01)
Net update LTCHs not reporting quality data	-1.0% (0.99)
Proposed Rule Adjustments	
Proposed average wage index budget neutrality adjustment	1.000077
Proposed budget neutrality adjustment for SSO payment methodology	0.9672
Proposed Standard Federal Rate, FY 2018	
LTCHs reporting quality data ($42,476.41∗1.01∗1.000077*0.9672)	$41,497.20
LTCHs not reporting quality data ($42,476.41∗0.99 ∗1.000077*0.9672)	$40,675.49
Proposed Fixed-loss Amount for High-Cost Outlier (HCO) Cases	
LTCH PPS standard federal payment rate cases	$30,081
Site neutral payment rate cases (same as the IPPS fixed-loss amount)	$26,713
Impact of Proposed Policy Changes on LTCH Payments in 2018	
Total estimated impact	-5.2% (-$238 million)
LTCH standard federal payment rate cases (58% of LTCH cases)	+0.4% (+$15 million)
Site neutral payment rate cases (42% of LTCH cases)**	-22% (-$252 million)

Summary of Proposed Changes to LTCH PPS Rates for FY 2018*
*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 2018" (see page 1780 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. Medicare Severity Long-Term Care Diagnosis-Related Group (MS-LTC-DRG) Classifications and Relative Weights for FY 2018

1. Background

Similar to FY 2017, the annual recalibration of the MS-LTC-DRG relative weights for FY 2018 is determined using data only from claims qualifying for LTCH PPS standard federal rate payment and claims that would have qualified if that rate had been in effect. Thereby, the MS-LTC-DRG relative weights are not used to determine the site neutral payment rate and site neutral payment case data are not used to develop the relative weights.

2. Patient Classification into MS-LTC-DRGs

CMS proposes to continue to apply the same MS-DRG classification system used for the IPPS payments to the LTCH PPS in the form of MS-LTC-DRGs. For FY 2018, the number of MS-DRGs is reduced from 757 to 754, as proposed. Other MS-DRG system updates also would be incorporated into the MS-LTC-DRG system for FY 2018 since the two systems share an identical base. Proposed DRG changes are described elsewhere in this summary and details can be found in sections II.F. of the preamble.

C. Proposed LTCH PPS Payment Rates

1. Proposed Annual Update for LTCHs

Section 411 of MACRA set the annual update for FY 2018 at 1.0 percent. Historically, CMS has used an estimated market basket increase to update the LTCH PPS.

For LTCHs failing to submit data to the LTCH Quality Reporting Program (QRP), the annual update would be reduced by 2.0 percentage points to -1 percent.

- Hospital reporting the required quality data would receive a 1.0 percent update.
- Hospitals not reporting the required quality date would receive a -1.0 percent update (1 percent minus 2 percentage points).

2. Area Wage Levels and Wage-Index

CMS sets out a proposed labor-related share of 66.3 percent for FY 2018.

3. Proposed LTCH Standard Federal Payment Rate Calculation

CMS proposes the following LTCH PPS standard federal payment rates for FY 2018:

- FY 2018 payment rate = $42,476.41 (FY 2017 payment rate) * 1.01 (statutory update factor) * 1.000077 (area wage budget neutrality factor) * 0.9672 (SSO budget neutrality factor) = $41,497.20

- For LTCHs not reporting data to the LTCH QRP: FY 2018 payment rate = $42,476.41 (FY 2017 payment rate) * 0.99 (statutory update factor less quality adjustment) * 1.000077 (area wage budget neutrality factor) * 0.9672 (SSO budget neutrality factor) = $40,675.49

4. Cost-of-Living (COLA) Adjustment

CMS proposes to continue updating the COLA factors for Alaska and Hawaii as it has done since FY 2014.

Proposed Cost-of-Living Adjustment Factors for Alaska and Hawaii Under the LTCH PPS for FY 2018	**FY 2014 through FY 2017**	**Proposed FY 2018**
Alaska		
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23	1.25
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23	1.25
City of Juneau and 80-kilometer (50-mile) radius by road	1.23	1.25
All other areas of Alaska	1.25	1.25
Hawaii		
City and County of Honolulu	1.25	1.25
County of Hawaii	1.19	1.21
County of Kauai	1.25	1.25
County of Maui and County of Kalawao	1.25	1.25

5. High-Cost Outlier (HCO) Case Payments

For FY 2018, CMS proposes that the fixed loss outlier target will be **$30,081**. This is equal to 7.975 percent of total estimated payments under the LTCH PPS. The fixed-loss amount is significantly higher than the FY 2017 amount of $22,728.

If an HCO case is also an SSO case, the HCO payment will equal 80 percent of the estimated case cost and the outlier threshold (SSO payment plus fixed-loss amount).

Consistent with 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 2018, CMS proposes a fixed-loss amount for site neutral payment rate cases of **$26,713**.

6. Proposed LTCH PPS Updates Related to IPPS DSH Payment Adjustment Methodology

For FY 2018, the DSH amount equals 68.51 percent of the operating Medicare DSH payment amount, based on the statutory Medicare DSH payment formula prior to the amendments made by the ACA adjusted to account for reduced payments for uncompensated care resulting from expansion of the insured population under the ACA.

D. Proposed Changes to the Short-Stay Outlier Adjustment Policy

Under the LTCH PPS, the "IPPS comparable amount" is applied to SSO cases. CMS received comments during the 2016 and 2017 IPPS/LTCH PPS rulemaking cycle that expressed concern with its existing SSO policy. Commenters noted that SSO cases are paid the "lesser of" various payment options, while non-SSO cases are paid the full MS-LTC-DRG payment, thus providing an economic incentive to hold a patient beyond the SSO threshold in order to increase the LTCH PPS payment.

Under its proposed policy, the SSO definition would remain unchanged, but the current payment adjustment options would be replaced with a single graduated per diem payment adjustment calculated using a blended payment rate that, as the length of stay increases, consists of a decreasing portion of the payment amount paid at the IPPS per diem amount (referred to as the "IPPS comparable amount") and an increasing portion paid at 120 percent of the MS-LTC-DRG per diem payment amount (referred to as the "LTCH PPS per diem amount"), with a maximum payment amount set at the full LTCH PPS standard federal payment rate.

CMS proposes, beginning with discharges occurring on or after October 1, 2017, to pay SSO cases solely on the "blended" option in the current SSO payment adjustment formula. The blend percentage is determined by dividing the covered length-of-stay of the case by the lesser of five-sixths of the geometric average length of stay of the LTC-DRG or 25 days, not to exceed 100 percent. This amount is then subtracted by 100 percent. CMS believes that, by paying SSO cases on this basis, it would reduce, if not eliminate, the payment "cliffs" (or payment differentials) inherent in its current payment methodology, as well as the financial incentives that appear to have resulted in potentially improper delays in patient discharges other than solely for medical reasons.

CMS notes that in assessing the potential impact of this proposed policy change, it found that the proposed change to the payment formula for SSOs would result in a net increase in aggregate Medicare LTCH payments compared to the current methodology. The decrease in expenditures from fewer delayed discharge cases is not large enough to offset the estimated increase in expenditures under the proposed SSO payment adjustment methodology.

Thus, CMS proposes to use a budget neutrality adjustment to offset the projected net increase in Medicare spending. CMS proposes to adjust the standard federal payment rate by a one-time, permanent factor that accounts for the projected change in estimated aggregate payments to LTCH PPS standard federal payment rate cases in FY 2018 due to the change in the payment methodology for SSO cases.

Based on its analysis of the claims data, CMS determines that the proposed change to the SSO payment methodology would result in a net increase in payments of approximately $102 million, and the proposed budget neutrality factor for the SSO payment methodology is 0.9672.

E. Temporary Exception to the Site Neutral Payment Rate for Certain Spinal Cord Specialty Hospitals

The Act, as amended by the 21st Century Cures Act, provides for a temporary exception to the site neutral payment rate for certain spinal cord specialty hospitals. Under this provision discharges occurring in cost reporting periods beginning during FY 2018 and FY 2019 for LTCHs that meet the statutory criteria are excepted from the site neutral payment rate. For these LTCHs, all discharges would be paid at the LTCH PPS standard federal payment rate.

In order for an LTCH to qualify for this temporary exception, the LTCH must:

- have been a not-for-profit LTCH on June 1, 2014, as determined by cost report data;
- have at least 50 percent of the discharges in calendar year 2013 from the LTCH for which payment was made under the LTCH PPS classified under MS-LTC–DRGs 28, 29, 52, 57, 551, 573, and 963; and
- have discharged inpatients (including both individuals entitled to, or enrolled for, Medicare Part A benefits and individuals not so entitled or enrolled) during FY 2014 who had been admitted from at least 20 of the 50 States.

The statute provides authority for the Secretary to implement the third criterion by program instruction or otherwise, and CMS plans to use this authority to provide details regarding the implementation of significant out-of-state admissions criterion through subrequlatory guidance.

F. Temporary Exception to the Site Neutral Payment Rate for Certain Discharges with Severe Wounds from Certain LTCHs

Section 231 of the Consolidated Appropriations Act of 2016 established a temporary exception to the site neutral payment rate for certain severe wound care discharges occurring prior to January 1, 2017 from LTCHs that are either located in rural areas or treated as being located in a rural area for IPPS purposes[1] and are hospitals within hospitals (HwHs) that were participating in Medicare, but excluded from the hospital IPPS on or before September 30, 1995. The provision had no beginning date and CMS implemented the provision effective upon publication of an interim final rule with comment period on April 21, 2016.

[1] As an LTCH is not an IPPS hospital, there are no statutory or regulatory provisions that would allow an LTCH to be treated as rural for IPPS purposes. To give meaning to this provision, CMS allowed an LTCH to apply to be reclassified as rural provided it meets the same criteria an IPPS hospital would meet for an urban to rural reclassification.

LTCHs that qualify for this provision are paid at the LTCH PPS rate for cases where the patient was treated for a severe wound defined as a Stage 3 wound, Stage 4 wound, unstageable wound, non-healing surgical wound, infected wound, fistula, osteomyelitis or wound in a patient with morbid obesity as identified in the claim from the LTCH.

Section 15010 of the 21st Century Cures Act creates a new exception to the site neutral payment under the LTCH PPS that is effective for discharges occurring in a cost reporting period beginning during fiscal year 2018. The requirement that the hospital be located in a rural area or be treated as located in a rural area for IPPS purposes does not apply. To qualify for the provision, the LTCH still must be an HwH that was participating in Medicare, but excluded from the IPPS on or before September 30, 1995.

As the current provision expires on January 1, 2017 and the new provision is not effective until at least October 1, 2017 (and later for hospitals with cost reporting periods that begin at a later date in FY 2018), there will be a minimum time period of at least nine months that severe wound cases subject to the provision will be paid at site-neutral or IPPS equivalent payment amounts if the cases do not meet the criteria for being paid at the LTCH PPS amount.

The new provision applies to discharges classified under MS–LTCH–DRG 602, 603, 539, or 540 and narrows the definition of severe wound discharge to a "wound" which is a stage 3 wound, stage 4 wound, unstageable wound, non-healing surgical wound, or fistula as identified in the claim from the LTCH. The term 'wound' means an injury involving division of tissue or rupture of the integument or mucous membrane with exposure to the external environment.

CMS notes, to the extent applicable, it is implementing this provision in an identical manner to its implementation of the amendments made by section 231 of the Consolidated Appropriations Act, which is codified in the LTCH PPS regulations at § 412.522(b)(2). CMS proposes to codify the requirements of this "new" temporary exception for severe wounds at new § 412.522(b)(3):

- CMS proposes to incorporate the definitions of "wound" and "severe wound" at § 412.522(b)(3)(i).
- CMS proposes that the patient must be treated for a severe wound that meets the statutory definition in order for the LTCH discharge to meet this "new" temporary exception for discharges for the treatment of severe wounds at §412.522(b)(3)(ii).
- CMS is codifying the requirement that this exception applies to MS-LTCH-DRG 602, 603, 539, or 540 at § 412.522(b)(3)(ii)(C).

CMS also proposes to codify the requirements to be a grandfathered HwH at new § 412.522(b)(3)(ii)(B). CMS notes that LTCHs that believe they meet these requirements should contact their MACs to verify.

G. Moratorium and Proposed Regulatory Delay of the Full Implementation of the "25-Percent Threshold Policy" Adjustment

CMS proposes to adopt a 1-year regulatory moratorium on the implementation of the 25-percent threshold policy until October 1, 2018. CMS states that this proposal is made in response to the further

statutory delays and its continued consideration of public comments received in the FY 2017 IPPS/LTCH PPS proposed rule to consolidate and streamline this policy. Specifically, CMS wants to examine when data are available whether this policy is still necessary given the application of the site neutral payment rate.

H. Change in Medicare Classification for Certain Hospitals

Under the authority provided by section 1206(d)(2) of the Pathway to SGR Reform Act, CMS created a special class of LTCH that is paid on the basis of reasonable costs rather than the LTCH PPS or a "site neutral" payment amount that applies in all other LTCHs. This provision is limited to hospitals that qualify as a "subclause II LTCH". While a subclause II hospital is paid similar to a hospital that is IPPS exempt and paid reasonable costs subject to a limit under the Tax Equity and Fiscal Responsibility Act (TEFRA), a "subclause II LTCH" remains an LTCH and is not considered a TEFRA hospital. The 21st Century Cures Act makes a subclause II hospital a TEFRA hospital rather than an LTCH which has implications for beneficiary liability and how the hospital is paid for high cost outlier cases.

II. Impact of Proposed Payment Rate and Policy Changes to LTCH PPS Payments for FY 2018

1. CMS Impact Analysis for LTCHs

CMS projects that the overall impact of the payment rate and policy changes, for all LTCHs from FY 2017 to FY 2018, will result in a decrease of 5.2 percent or $238 million in aggregate payments (from $4.609 billion to $4.371 billion). This estimated decrease in payments reflects:

- $15 increase in payments to LTCH PPS standard federal payment rate cases
- $252 decrease in payments to site neutral payment rate cases of approximately

This does not include separate estimates from the Office of the Actuary who projects an additional increase in aggregate FY 2018 LTCH PPS payments of approximately $65 million for its proposal to delay full implementation of the 25-percent threshold policy for FY 2018 and its proposed implementation of certain provisions of the 21st Century Cures Act.

Summary of Impact of Proposed Changes to LTCH PPS for Standard Federal Payment Rate Cases for FY 2018*		
LTCH Classification	**Number of LTCHs**	**Estimated percent change in payments per discharge**
All LTCH providers	415	+0.4%
By Location:		
Rural	21	-0.7%
Urban	394	+0.5%
By Ownership Type:		
Voluntary	72	+0.0%
Proprietary	328	+0.5%
Government	15	-1.0%
By Region		

New England	12	+1.0%
Middle Atlantic	25	+0.7%
South Atlantic	66	+0.7%
East North Central	68	+0.3%
East South Central	34	+0.8%
West North Central	27	-0.8%
West South Central	127	-0.1%
Mountain	31	+0.3%
Pacific	25	+1.1%
*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 2018," (see page 1780 of display copy).		

2. Tables

The complete set of tables providing detail on the proposed LTCH PPS for FY 2018 is at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/LTCHPPS-Regulations-and-Notices-Items/LTCH-PPS-CMS-1677-P.html

The information at that link provides:

- Table 8C: Proposed LTCH PPS Statewide Average Cost-to-Charge Ratios
- Table 11: Proposed MS-LTC-DRGs, relative weights, geometric average length of stay, SSO threshold, and IPPS comparable threshold for FY 2018
- Table 12A: Proposed LTCH PPS Wage Index for Urban Areas for FY 2018
- Table 12B: Proposed LTCH PPS Wage Index for Rural Areas for FY 2018
- Table 13A: Composition of proposed low-volume quintiles for MS-LTC-DRGs for FY 2018
- Table 13B: Proposed no volume MS-LTC-DRG crosswalk for FY 2018
- LTCH PPS FY 2018 Proposed Impact File

A. Long-Term Care Hospital Quality Reporting Program (LTCH QRP)

An LTCH that does not meet the requirements of participation in the LTCHQR Program for a rate year is subject to a 2.0 percentage point reduction in the update factor for that year. In the impact analysis presented in Appendix A to the final rule, CMS reports that 41 out of 424 LTCHs were found to be noncompliant with the LTCHQR Program and therefore did not receive the full update factor for the FY 2017 payment determination.

1. Collection of Standardized Patient Assessment Data under the LTCH QRP

The IMPACT Act requires that beginning in FY 2019, LTCHs must report standardized patient assessment data 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. The standardized patient assessment data must be reported at least with respect to

LTCH admissions and discharges, but the Secretary may require the data to be reported more frequently.

The specific data elements that CMS proposes to require that LTCHs report as standardized patient assessment data are discussed in the proposed rule. The table below lists the elements by category, identifies the current PAC patient assessment instruments that include the proposed elements (or similar ones) and indicates whether the data elements are included in the current Long-Term Care Hospital Continuity Assessment Record and Evaluation Data Set (LTCH Care Data Set or LCDS) or would be newly added. For the FY2020 payment determination, LTCHs would be required to report all but three of the elements for all admissions and discharges beginning April 1, 2018 through December 31, 2018. For subsequent payment years, reporting would be for a full calendar year. The three exceptions are the elements BIMS, hearing, and vision elements, for which reporting would only be required for assessments at admission, and not discharge.

In sum, CMS says that under its proposals LTCHs would report 25 new standardized patient assessment data elements with respect to LTCH admissions and 17 new standardized patient assessment data elements with respect to LTCH discharges.

Proposed Standardized Patient Assessment Data Elements, by Category		
Data Elements	**Current Use/Test of Elements***	**Change to LCDS**
Functional Status		
Elements to calculate the measure: 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)	LCDS	No change
Cognitive Function and Mental Status		
Brief Interview for Mental Status (BIMS)	MDS 3.0 IRF-PAI PAC PRD	Add to LCDS assess at admission only
Confusion Assessment Method	LCDS MDS 3.0 PAC PRD	No change
Behavioral Signs and Symptoms	MDS 3.0 OASIS-C2 PAC PRD	Add to LCDS (MDS version)
Patient Health Questionnaire-2	MDS 3.0 OASIS-C2 PAC PRD	Add to LCDS
Special Services, Treatments, and Interventions		
Cancer Treatment: Chemotherapy (IV, Oral, Other)	MDS 3.0 PAC PRD	Add to LCDS
Cancer Treatment: Radiation	MDS 3.0	Add to LCDS
Respiratory Treatment: Oxygen Therapy (Continuous, Intermittent)	MDS 3.0	Add to LCDS

Proposed Standardized Patient Assessment Data Elements, by Category		
Data Elements	**Current Use/Test of Elements***	**Change to LCDS**
	OASIS-C2 PAC PRD	
Respiratory Treatment: Suctioning (Scheduled, As needed)	MDS 3.0 PAC PRD	Add to LCDS
Respiratory Treatment: Tracheostomy Care	MDS 3.0 PAC PRD	Add to LCDS
Respiratory Treatment: Non-invasive Mechanical Ventilator (BiPAP, CPAP)	LCDS MDS 3.0 OASIS-C2 PAC PRD	Expand LCDS
Respiratory Treatment: Invasive Mechanical Ventilator	LCDS MDS 3.0 PAC PRD	No change
Other Treatment: Intravenous (IV) Medications (Antibiotics, Anticoagulation, Other)	MDS 3.0 OASIS-C2 PAC PRD	Add to LCDS
Other Treatment: Transfusions	MDS 3.0 OASIS-C2 PAC PRD	Add to LCDS (MDS version)
Other Treatment: Dialysis (Hemodialysis, Peritoneal dialysis)	LCDS MDS 3.0 PAC PRD	Expand LCDS
Other Treatment: Intravenous (IV) Access (Peripheral IV, Midline, Central line, Other)	MDS 3.0 OASIS PAC PRD	Add to LCDS
Nutritional Approach: Parenteral/IV Feeding	LCDS MDS 3.0 IRF-PAI OASIS-C2 PAC PRD	No change except renaming
Nutritional Approach: Feeding Tube	MDS 3.0 OASIS-C2 IRF-PAI PAC PRD	Add to LCDS
Nutritional Approach: Mechanically Altered Diet	MDS 3.0 OASIS-C2 IRF-PAI PAC PRD	Add to LCDS
Nutritional Approach: Therapeutic Diet	MDS 3.0 PAC PRD	Add to LCDS
Medical Condition and Comorbidity Data		
Elements to calculate the current and proposed pressure ulcer measures: Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) and	LCDS	No change

Proposed Standardized Patient Assessment Data Elements, by Category		
Data Elements	**Current Use/Test of Elements***	**Change to LCDS**
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury		
Impairment		
Hearing	MDS 3.0 OASIS C-2 PAC PRD	Add to LCDS (MDS version) assess at admission only
Vision	MDS 3.0 OASIS C-2 PAC PRD	Add to LCDS (MDS version) assess at admission only
*This column reflects whether the proposed rule indicates that the specific elements proposed or similar or related elements are included in thP{e current PAC assessment instruments or tested in the PAC PRD. The PAC instruments referenced are: Long-Term Care Hospital Continuity Assessment Record and Evaluation Data Set (LTCH CARE Data Set or LCDS); MDS for Skilled Nursing Facilities; OASIS C-2 for home health agencies; and Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI).		

2. LTCH QRP Measures for FY 2020

Beginning with the FY 2020 payment determination, CMS proposes to replace one measure in the LTCH QRP, remove another measure, and add two new measures.

- *Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) (NQF #0678)*: This is replaced by Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury. CMS intends to submit the measure for NQF endorsement at the earliest opportunity. The MAP provided conditional support for using the new measure in the LTCH QRP.
- Two new measures related to mechanical ventilation would be added to the LTCH QRP measure set.
    - Mechanical Ventilation Process Quality Measure: Compliance with Spontaneous Breathing Test by Day 2 of the LTCH Stay
    - Mechanical Ventilation Outcome Quality Measure: Ventilator Liberation Rate.

  The MAP reviewed these measures in December 2015 and encouraged further development. CMS says that it subsequently continued to make improvements in the measures and its findings were presented to the MAP at its October 2016 feedback loop meeting. CMS intends to submit the measures to NQF for review and endorsement.

- *All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from LTCHs*: Removed from the LTCH QRP. CMS has reconsidered comments it received during last year's rulemaking expressing concern about the multiplicity of readmission measures and the overlap between this measure and the All-Cause Readmission and Potentially Preventable Readmission (PPR) 30-Day Post-Discharge measures.

3. Public reporting

CMS previously adopted policies for public display of LTCH QRP data on the *LTCH Compare* website, and for confidential feedback reports on these LTCH QRP measures to LTCHs prior to public reporting.

In this rule, pending the availability of data, CMS proposes to report data in 2018 on additional measures. A table in the proposed rule lists the 7 previously finalized measures and 7 proposed additional measures. These are indicated in the summary table below.

LTCH QRP Measures, by Year ***Proposals in Italics***				
Measure Title	**FY 2018**	**FY 2019**	**FY 2020**	**Public Reporting in CY 2018**
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	X	*Replace*	X
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury			*X*	
Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680)	X	X		X
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		X
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)	X	X	*Remove*	
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*

LTCH QRP Measures, by Year ***Proposals in Italics***				
Measure Title	**FY 2018**	**FY 2019**	**FY 2020**	**Public Reporting in CY 2018**
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		
Medicare spending per beneficiary MSPB-PAC LTCH	X	X		*X*
Discharge to Community PAC LTCH	X	X		*X*
Preventable Readmissions 30 Days Post LTCH Discharge	X	X		*X*
Drug Regimen Review Conducted with Follow-up			X	
Mechanical Ventilation Process Measure: Compliance with Spontaneous Breathing Test by Day 2 of the LTCH Stay			*X*	
Mechanical Ventilation Outcome Measure: Ventilator Liberation Rate			*X*	