Medicare Long-Term Care Hospital Prospective Payment System

Proposed Payment Rule Brief Provided by the Wisconsin Hospital Association

Program Year: FFY 2023

Overview and Resources

On April 18, 2022, the Centers for Medicare and Medicaid Services (CMS) released the DISPLAY copy of the federal fiscal year (FFY) 2023 proposed payment rule for the Medicare Long-Term Care Hospital Prospective Payment System (LTCH PPS). The proposed rule reflects the annual update to the Medicare fee-for-service (FFS) LTCH payment rates and policies.

A copy of the resources related to the LTCH PPS is available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html.

On May 10, 2022, an online version of the proposed rule will become available at https://www.federalregister.gov/d/2022-08268.

Program changes proposed by CMS are effective for discharges on or after October 1, 2022, unless otherwise noted. CMS estimates the overall economic impact of this proposed payment rate update to be an increase of $25 million in aggregate payments to LTCHs in FFY 2023 over FFY 2022.

Comments on the proposed rule are due to CMS by June 17, 2022 and can be submitted electronically at https://www.regulations.gov by using the website's search feature to search for file code "1771-P".

Note: Text in italics is extracted from the August 13, 2021 or the April 18, 2022 *Federal Register*.

LTCH Payment Rate

DISPLAY pages 44 – 52, 964 – 969, 1,011 – 1,017, 1,595 - 1,597, and 1,637 – 1,638

Only LTCH discharges that meet certain clinical criteria (detailed below) will continue to be paid at the standard LTCH PPS payment rates. LTCH discharges that do not meet the established clinical criteria will continue to be paid the lower site-neutral payment rates (with some specified exclusions), which are based on the IPPS rates and are the lesser of either the IPPS comparable per diem amount, including any outlier payments, or 100 percent of the estimated cost of the case. The IPPS comparable per diem payment amount is capped at the lower of the IPPS comparable per diem amount and the full comparable amount to what would otherwise be paid under IPPS.

CMS uses the following criteria in order to identify cases eligible for a standard LTCH PPS payment:

- The LTCH discharge does not have a principal diagnosis relating to a psychiatric diagnosis or to rehabilitation;
- A case must be "immediately discharged" from an inpatient PPS hospital. This immediate discharge will be evidenced by the dates of discharge and admission to the LTCH; and
  - One or both of these criteria:
    - Must receive at least three days of care in an ICU or CCU during the prior hospital stay. CMS will use the full set of ICU and CCU revenue codes when counting a patient's ICU and CCU days during the prior acute care hospital stay; and/or
    - The patient received at least 96 hours of ventilator services in the LTCH stay.

For calculating whether an LTCH or LTCH satellite meets the existing greater than 25-day average length of stay requirement, cases paid at the site neutral rate and those paid by Medicare Advantage are excluded.

In addition, the Bipartisan Budget Act reduces the IPPS comparable amount in the site neutral payment rate calculation by 4.6% for FFYs 2018 – 2026.

The LTCH discharge payment percent is the percent of all Medicare FFS discharges that are paid the standard LTCH payment rate, and not the site neutral payment rate.

For all cost reporting periods beginning on or after October 1, 2020, the IPPS equivalent payment rate is mandated for ALL discharges for LTCHs that fail to meet the applicable discharge threshold in the prior FFY (less than 50% of patients for whom the standard LTCH PPS payment is made).

In past years, CMS has utilized the best available data sources for LTCH rate setting, including MedPAR claims data, for the fiscal year that is two years prior and hospital cost repot (HCRIS) data beginning three fiscal years prior to the rate setting year (FFYs 2021 and 2020, respectively for FFY 2023). However, in the FFY 2022 IPPS final rule, CMS adopted the use of FFY 2019 data due to FFY 2020 data being significantly impacted by the COVID-19 public health emergency (PHE). Similarly, a CMS analysis has found that both the FFY 2021 MedPAR and FFY 2020 HCRIS data also contained figures that were significantly impacted by the PHE. CMS believes that, due to the expected continued impact of COVID-19 on hospitalizations, the use of the FFY 2021 data would still be appropriate, with the following modifications:

- Modifying the calculation of the MS-LTC-DRG relative weights by averaging two sets of weights, one including and excluding COVID-19 claims, to reduce the effect of COVID-19 cases on relative weights; and
- Inflating the charges from the FYY 2021 MedPAR claims using a factor computed by comparing the average covered charge per case in the March 2019 MedPAR file of FFY 2018 to the average covered charge per case in the March 2020 MedPAR file of FFY 2019 to determine the outlier fixed-loss amount. CMS also proposes to adjust the cost-to-charge ratios (CCRs) from the December 2021 update of the provider specific file (PSF) by comparing the percentage change in the national average case-weighted CCR from the March 2019 PSF to that in the March 2020 PSF.

CMS is also requesting comments on the use of FFY 2021 data for FFY 2023 rate setting without these proposed modifications, noting that the FFY 2023 outlier fixed-loss amount will be significantly higher under this alternative approach. Supplemental information, including relative weights and the fixed-loss amount, can be found in Appendix A of the proposed rule (*DISPLAY* pages 1,766 – 1,769).

Incorporating the proposed updates and the effects of budget neutrality adjustments, the table below lists the full LTCH standard federal rate for FFY 2023 compared to the rate currently in effect:

	Final FFY 2022	Proposed FFY 2023	Percent Change
LTCH Standard Federal Rate	**$44,713.67**	**$45,952.67**	**2.77%**

The table below provides details of the proposed updates for the LTCH standard federal rate for FFY 2023:

	LTCH Rate Updates and Budget Neutrality Adjustments
Marketbasket Update	**+3.1%**
ACA Pre-Determined Adjustment	**-0.4 percentage points (PPT)**
Wage Index Budget Neutrality Adjustment	**1.000691**
Overall Rate Change	**2.77%**

Wage Index Labor-Related Share, CBSA and COLA

DISPLAY pages 1,597 – 1,616

As in prior years, CMS is proposing to continue to use the most recent inpatient hospital wage index, the FFY 2023 pre-rural floor and the pre-reclassified hospital wage index, to adjust payment rates under the LTCH PPS for FFY 2023.

The wage index, which is used to adjust payment for differences in area wage levels, is applied to the portion of the LTCH standard federal rate that CMS considers to be labor-related. CMS estimated the labor-related portion of the LTCH standard federal rate, using the 2017-based LTCH marketbasket. Based on the updates to the marketbasket value, CMS is proposing an increase to the labor-related share from 67.9% for FFY 2022 to 68.2% for FFY 2023.

In the past, CMS implemented wage index transition policies with limited duration in order to phase in significant changes to labor market areas with the intent to mitigate short-term negative impact to affected providers. Additionally, CMS recognizes that there are also year-to-year fluctuations in wage indexes that can occur due to external factors beyond a provider's control. In order to reduce large swings in year-to-year wage index changes and increase the predictability of LTCH payments, CMS is proposing to apply a 5% cap on any decrease of the FFY 2023 LTCH wage index, and all future LTCH wage indexes, compared with the previous year's wage index. The cap is proposed to be applied regardless of the reason for the decrease and implemented in a budget neutral manner. This also means that if an LTCH's prior FFY wage index is calculated with the application of the 5% cap, the following year's wage index would not be less than 95% of the LTCH's capped wage index in the prior FFY. Lastly, CMS proposes that a new LTCH be paid the wage index for the area in which it is geographically located for its first full or partial FFY with no cap applied, because a new LTCH would not have a wage index in the prior FFY.

CMS is proposing the 5% permanent cap on the IPPS comparable wage indexes as well for the calculation of site-neutral payments with the same stipulations, but not applied in a budget neutral manner.

CMS proposes a wage index and labor-related share budget neutrality factor of 1.000691 for FFY 2023 to ensure that aggregate payments made under the LTCH PPS are not greater or less than would otherwise be made if wage adjustments had not changed. This budget neutrality factor also includes the impact of the proposed 5% cap on LTCH wage index decreases.

Updates to the MS-LTC-DRGs

DISPLAY pages 970 – 1,010

Each year, CMS updates the MS-LTC-DRG classifications and relative weights. These updates are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. Although the DRGs used to classify patients under the LTCH PPS are the same as those used under the inpatient PPS, the relative weights are different for each setting. The MS–LTC DRG relative weights are determined using only data from LTCH discharges that meet the criteria for exclusion from the site neutral payment rate (that is, LTCH PPS standard Federal payment rate cases). CMS is proposing to continue to use its existing methodology to determine the MS-LTC-DRG relative weights.

As stated earlier, CMS believes utilization patterns reflected in the FFY 2021 LTCH claims data were impacted by the COVID-19 PHE, and therefore CMS is proposing to modify the calculation of the MS-LTC-DRG relative weights by averaging two sets of weights, one including and the other excluding COVID-19 claims.

In previous rulemaking, CMS finalized policies which limited significant declines in MS-LTC-DRG relative weights from one federal fiscal year to the next, with special consideration going towards lower volume MS-DRGs. In an effort to address concerns from commenters and to mitigate financial impacts due to significant fluctuations,

beginning FFY 2023, CMS is proposing a permanent 10% cap on the reduction of a MS-LTC-DRG's relative weight from in a given year compared to the weight in the previous year, implemented in a budget neutral manner. As such, CMS is also proposing to apply a budget neutrality adjustment of 0.9966694 directly to all MS-LTC-DRGs, not to the LTCH standard amount, unlike a similar proposal for the IPPS.

This proposed cap would only apply to a given MS-LTC-DRG with its current MS-DRG number. This cap would not apply to the relative weight for any new or renumbered MS-DRGs for the year. The 10% cap would also not apply to no-volume MS-LTC-DRGs.

The full list of proposed MS-LTC-DRGs for FFY 2023 can be found at: https://www.cms.gov/files/zip/fy-2023-ms-ltc-drg-table-11.zip.

HCO Payments

DISPLAY pages 1,616 – 1,635

High cost outlier (HCO) payments were established under the LTCH PPS to provide additional payments for very costly cases. Outlier payments are made if the estimated cost of the case exceeds the payment for the case plus a fixed-loss amount. Costs are determined by multiplying the facility's overall CCR by the allowable charges for the case. When a case qualifies for an outlier payment, CMS pays 80% of the difference between the estimated cost of the case and the fixed-loss amount as a separate outlier payment, in addition to the traditional DRG payment.

If an LTCH's CCR is higher than the LTCH Total CCR ceiling, the LTCH is assigned the statewide average CCR, which would then be used in the HCO formula. CMS is proposing a Total CCR ceiling of 1.321 for FFY 2023 for both LTCH PPS standard Federal payment rate cases and site neutral payment rate cases.

In the FFY 2022 final rule, CMS adopted a technical change to determine the LTCH charge inflation factor based on the historical growth in charges for LTCH PPS standard Federal payment rate cases, calculated using historical MedPAR claims data. In this proposed rule, CMS is proposing not to use the charge inflation factor derived from the most recently available data because it is abnormally high due to the impacts of the COVID-19 pandemic. Instead, CMS would use the same charge factor as FFY 2022, which was based on growth in charges between FFY 2018 and FFY 2019.

CMS made a second change in the FFY 2022 final rule that adjusted CCRs obtained from the best available PSF data by an adjustment factor that is calculated based on historical changes in the average case weighted CCR for LTCHs. However, CMS is also proposing not to use the most recently available data to calculate the CCR adjustment factor, due to the impact of COVID-19, and instead use the adjustment factor derived in FFY 2022 which was based on changes in CCRs that occurred between the March 2019 PSF and the March 2020 PSF.

There are two separate high-cost outlier targets – one for LTCH PPS standard Federal payment rate cases and one for site neutral payment rate cases. Under the two-tiered system, there is an 8.0% high-cost outlier target for standard LTCH PPS cases using only standard LTCH cases. For site neutral cases, CMS uses a 5.1% target, the same as the operating IPPS target. CMS is proposing an increase to the threshold for cases paid under the LTCH standard Federal payment rate from $33,015 in FFY 2022 to $44,182 in FFY 2023. CMS is also proposing a fixed-loss threshold for cases paid under the site neutral payment rate increase from $30,988 in FFY 2022 to $43,214 in FFY 2023. This proposed fixed-loss amount for site-neutral payment rate cases is the same as the FFY 2023 proposed IPPS fixed-loss amount.

CMS calculates the LTCH rate setting using the best data available, as described earlier in this brief, but is considering an alternative approach to calculate high-cost outlier targets without any proposed methodological changes. With this alternative, the fixed-loss threshold for the FFY 2023 LTCH standard Federal payment rate would be $61,842.

CMS is proposing to continue to make an additional HCO payment for the cost of a case that exceeds the HCO threshold amount that is equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the fixed-loss amount and the amount paid under the SSO policy) for both LTCH standard cases and site-neutral cases.

To ensure that estimated HCO payments payable to site-neutral payment rate cases would not result in any increase in aggregated payments, CMS is proposing to continue to apply a budget neutrality adjustment that reduces site-neutral payment rate payments by 5.1% in FFY 2023 (same as FFY 2022). CMS will apply the 5.1% only to the non-HCO portion of the site-neutral rate payment amount.

SSO Payments

DISPLAY page 994

Short-stay outlier (SSO) payments were established under the LTCH PPS to ensure that LTCH payments, which are predicated on long lengths of stay (LOS), are not applied to cases where the patient may have received only partial treatment at a LTCH. A SSO case is a covered length of stay that is less than or equal to $5/6^{th}$ of the geometric average length of stay for a specific MS-LTC-DRG. Generally, the average length of stay for an LTCH is 25 days.

CMS did not propose any major changes to the SSO policy.

Updates to the LTCH Quality Reporting Program (LTCH QRP)

DISPLAY pages 1,266 – 1,296

Beginning in FFY 2014, the applicable annual update is reduced by two percentage points for any LTCH that does not meet the QRP requirements.

The following table lists the previously adopted LTCH QRP measures and payment determination years.

Measure	NQF #	Finalized Cross-Setting Measure	Payment Determination Year
National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	#0138		FFY 2015 and beyond
NHSN Central Line-Associated Blood Stream Infection (CLABSI) Outcome Measure	#0139		FFY 2015 and beyond
Influenza Vaccination Coverage among Healthcare Personnel	#0431		FFY 2016 and beyond
NHSN Facility-Wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure	#1717		FFY 2017 and beyond
Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay)	#0674	Yes	FFY 2018 and beyond
Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function	#2631	Yes	FFY 2018 and beyond
Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function	#2631	Yes	FFY 2018 and beyond
Functional Outcome Measure: Change in Mobility among LTCH Patients Requiring Ventilator Support	#2632		FFY 2018 and beyond
Medicare Spending Per Beneficiary (MSPB) – Post Acute Care (PAC) LTCH Quality Reporting Program (QRP)	N/A	Yes	FFY 2018 and beyond
Discharge to Community – Post Acute Care PAC LTCH QRP	N/A	Yes	FFY 2018 and beyond
Potentially Preventable 30-Day Post-Discharge Readmission Measure for LTCH QRP	N/A	Yes	FFY 2018 and beyond

Drug Regimen Review Conducted With Follow-Up for Identified Issues- PAC LTCH QRP	N/A	Yes	FFY 2020 and beyond
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	N/A		FFY 2020 and beyond
Compliance with Spontaneous Breathing Trial (SBT) by Day 2 of the LTCH Stay	N/A		FFY 2020 and beyond
Ventilator Liberation Rate	N/A		FFY 2020 and beyond
Transfer of Health Information to the Provider Post-Acute Care	N/A		FFY 2022 and beyond
Transfer of Health Information to the Patient Post-Acute Care	N/A		FFY 2022 and beyond
COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)	N/A		FFY 2023 and beyond

CMS did not propose any new measures for the LTCH QRP.

Request for Information – LTCH QRP Quality Measure Concepts under Consideration for Future Years

DISPLAY pages 1,268 – 1,269

CMS is asking for input on the importance, relevance, and applicability of a cross-setting functional measure that would incorporate the domains of self-care and mobility, health equity measures, and the value of a PAC – COVID-19 Vaccination Coverage among Patients measure.

Request for Information – Inclusion of the NHSN Healthcare-Associated Clostridioides difficile Infection Outcome Measure

DISPLAY pages 1,269 – 1,275

CMS is also specifically seeking comment on the following, with regards to the inclusion of the NHSN Healthcare-Associated *Clostridioides* difficile Infection Outcome measure:

- *"Would you support utilizing LTCH EHRs as the mechanism of data collection and submission for LTCH QRP measures?*
- *Would your EHR support exposing data via HL7 FHIR to a locally installed MCT?*
- *For LTCHs using certified health IT systems, how can existing certification criteria under the Office of the National Coordinator (ONC) Health Information Technology (IT) Certification Program support reporting of these data? What updates, if any, to the Certification Program would be needed to better support capture and submission of these data?*
- *Is a transition period between the current method of data submission and an electronic submission method necessary? If so, how long of a transition would be necessary, and what specific factors are relevant in determining the length of any transition?*
- *Would vendors, including those that service LTCHs, be interested in or willing to participate in pilots or voluntary electronic submission of quality data?*
- *Do LTCHs anticipate challenges, other than the adoption of EHR, to adopting the NHSN HA-CDI measure, and if so, what are potential solutions for those challenges?"*

Request for Information – Overarching Principles for Measuring Healthcare Quality Disparities Across CMS Quality Programs

DISPAY pages 1,275 – 1,295

CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing care and support.

CMS requests comment on the following topics, which concern health equity:

- *"Identification of Goals and Approaches for Measuring Healthcare Disparities and Using Measure Stratification Across CMS Quality Reporting Programs*
    - *The use of the within- and between-provider disparity methods in IPFs to present stratified measure results.*
    - *The use of decomposition approaches to explain possible causes of measure performance disparities*
    - *Alternative methods to identify disparities and the drivers of disparities*
- *Guiding Principles for Selecting and Prioritizing Measures for Disparity Reporting*
    - *Principles to consider for prioritization of health equity measures and measures for disparity reporting, including prioritizing stratification for validated clinical quality measures, those measures with established disparities in care, measures that have adequate sample size and representation among healthcare providers and outcomes, and measures of appropriate access and care.*
- *Principles for Social Risk Factor and Demographic Data Selection and Use*
    - *Principles to be considered for the selection of social risk factors and demographic data for use in collecting disparity data including the importance of expanding variables used in measure stratification to consider a wide range of social risk factors, demographic variables and other markers of historic disadvantage. In the absence of patient -reported data we will consider use of administrative data, area-based indicators and imputed variables as appropriate.*
- *Identification of Meaningful Performance Differences*
    - *Ways that meaningful difference in disparity results should be considered.*
- *Guiding Principles for Reporting Disparity Measures*
    - *Guiding principles for the use and application of the results of disparity measurement.*
- *Measures Related to Health Equity*
    - *The usefulness of a HESS score for IPFs, both in terms of provider actionability to improve health equity, and in terms of whether this information would support Care Compare website users in making informed healthcare decisions.*
    - *The potential for a structural measure assessing an IPF's commitment to health equity, the specific domains that should be captured, and options for reporting this data in a manner that would minimize burden.*
    - *Options to collect facility-level information that could be used to support the calculation of a structural measure of health equity.*
    - *Other options for measures that address health equity."*

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