Medicare Long-Term Care Hospital
Prospective Payment System

Payment Rule Brief — FINAL RULE
Program Year: FFY 2014

Overview and Resources

On August 19, 2013, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2014 final payment rule for the Medicare Long-Term Care Hospital Prospective Payment System (LTCH PPS). The final rule reflects the annual update to the Medicare fee-for-service (FFS) LTCH payment rates and policies based on regulatory changes put forward by CMS and legislative changes previously adopted by Congress.

A copy of the final rule Federal Register (FR) and other resources related to the LTCH PPS are available on the CMS Web site at https://www.cms.gov/Medicare/Medicare‐Fee‐for‐Service‐Payment/LongTermCareHospitalPPS/index.html.

An online version of the final rule is available at https://federalregister.gov/a/2013‐18956.

A brief of the final rule is provided below along with FR page references for additional details. Program changes adopted by CMS will be effective for discharges on or after October 1, 2013 unless otherwise noted.

**LTCH Payment Rate**
*FR pages 50,761-50,765 and 50,992-50,994*

Incorporating the final updates with the effect of budget neutrality adjustments, the table below lists the LTCH standard federal rate for FFY 2014 compared to the rates currently in effect:

<table>
<thead>
<tr>
<th>LTCH Standard Federal Rate</th>
<th>Final FFY 2013*</th>
<th>Final FFY 2014</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>$40,397.96</td>
<td>$40,607.31</td>
<td>+0.5%</td>
<td></td>
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</table>

* CMS is using two different LTCH rates during FFY 2013. One that took effect on December 29 and one that was in effect from October 1 through December 28. The final FFY 2013 rate and the percent change shown above are based on the rate that took effect on December 29. The rate used from October 1 through December 28 was $40,915.95.

The table below provides details of the adopted updates for the LTCH standard federal rate for FFY 2014. The finalized updates do not vary significantly from the proposed rule.

<table>
<thead>
<tr>
<th>Final LTCH Rate Updates</th>
<th></th>
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<tbody>
<tr>
<td>Marketbasket (MB) Update</td>
<td>+2.5%</td>
</tr>
<tr>
<td>Affordable Care Act (ACA)-Mandated Productivity MB Reduction</td>
<td>-0.5%</td>
</tr>
</tbody>
</table>
The labor-related portion of the LTCH standard federal rate is adjusted for differences in area wage levels using a wage index. CMS did not propose and is not adopting any major changes to the calculation of Medicare LTCH wage indexes. As has been the case in prior years, CMS will use the most recent inpatient hospital wage index, the FFY 2014 pre-rural floor and pre-reclassified hospital wage index, to adjust payment rates under the LTCH PPS for FFY 2014. A complete list of the final wage indexes to be used for payment in FFY 2014 is available in Tables 12A and 12B on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/LTCPPS-Regulations-and-Notices-Items/LTC-PPS-CMS-1599-F.html?DLPage=1&DLSort=3&DLSortDir=descending.
Based on the final updates to this year’s marketbasket value, CMS will reduce the labor-related share of the standard rate from 63.096% for FFY 2013 to 62.537% for FFY 2014 (proposed at 62.717%). This change will provide slight increases in payments to LTCHs with a wage index less than 1.0.

For LTCHs in Alaska and Hawaii, the LTCH PPS provides a cost-of-living adjustment (COLA). The COLA is made by multiplying the nonlabor-related portion of the standard rate by the applicable COLA factor. CMS is adopting its proposal to update the COLA factors for FFY 2014 based on a process outlined and adopted in last year’s LTCH final rule. As adopted, the COLA for the County of Hawaii will be revised upward slightly; all other COLAs under the updated methodology will remain unchanged from FFY 2013. A list of the finalized COLA factors for FFY 2014 is available on FR page 50,998.

**Updates to the MS-LTC-DRGs**
*FR pages 50,753-50,760*

Each year, CMS updates the Medicare Severity-Long-Term Care-Diagnosis Related Group (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 identical to those used under the inpatient PPS, the relative weights are different for each setting.

CMS did not propose and is not adopting any major changes to the way the MS-LTC-DRG payment weights are calculated for FFY 2014. As adopted, when compared to the weights currently in effect, the weights for the top 50 utilized MS-LTC-DRGs (80% of cases) will change on average by +0.83% (with a range of up to -3.4% and +8.0%). The finalized FFY 2014 MS-LTC-DRGs and weights are available in Table 11 on the CMS Web site at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/LTCHPPS-Regulations-and-Notices-items/LTCH-PPS-CMS-1599-F.html?DLPage=1&DLSort=3&DLSortDir=descending](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/LTCHPPS-Regulations-and-Notices-items/LTCH-PPS-CMS-1599-F.html?DLPage=1&DLSort=3&DLSortDir=descending).

**HCO Payments**
*FR pages 50,998-51,0001*

High cost outlier (HCO) payments were established under the LTCH PPS to provide additional payments for extremely 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 cost-to-charge ratio (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.

CMS has established a target of 8.0% of total LTCH PPS payments to be set aside for HCOs. To maintain total outlier payments at 8.0% of total LTCH PPS payments, CMS will decrease the fixed-loss amount by 13.6% from $15,408 in FFY 2013 to $13,314 in FFY 2014 (proposed at $14,139).

**SSO Payments**
*FR page reference not available*

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. Currently, the SSO outlier policy applies to cases with a covered LOS of less than or equal to 5/6 of the average LOS for the MS-LTC-DRG. CMS did not propose and is not adopting any major changes to the SSO policy for FFY 2014. Payments for SSO cases will continue to be based on the lowest of four calculated amounts:

1) the full MS-LTC-DRG amount;
2) 120% of the MS-LTC-DRG per diem;
3) 100% of cost; or

Depending on the LOS of the SSO case relative to the ‘IPPS comparable threshold’:

4) 100% of the comparable inpatient PPS MS-DRG per diem or a blend of that amount and 120% of the MS-LTC-DRG per diem. The IPPS comparable threshold is defined as the geometric ALOS for the same DRG under the Inpatient Prospective Payment System.

**Application of the 25% Payment Adjustment Threshold Policy**

*FR pages 50,768-50,772*

Since 2005, CMS has pursued a policy to reduce LTCH payment amounts to the inpatient PPS amount for LTCHs that admit more than 25% of Medicare cases from an onsite or neighboring inpatient acute care hospital. Legislative moratoria delayed the full application of the 25% payment adjustment threshold for about 5 years (through FFY 2012). The moratoria applied a less restrictive threshold to certain LTCHs and exempts other classes of LTCHs from the threshold altogether. During last year’s rulemaking cycle, CMS used its regulatory authority to extend the moratoria for one additional year, through FFY 2013. CMS will not be extending this relief for FFY 2014. As a result, full application of the 25% payment adjustment threshold will apply for cost reporting periods beginning on or after October 1, 2013. CMS notes that payment methodology changes to the LTCH PPS under consideration by the agency could render the 25% payment adjustment threshold policy unnecessary in the future.

**Updates to the LTCHQR Program**

*FR pages 50,853-50,887*

The ACA required CMS to implement a quality data pay-for-reporting program for providers paid under the LTCH PPS. CMS first adopted measures and policies in the FFY 2012 rulemaking cycle to implement the Long-Term Care Hospital Quality Reporting (LTCHQR) Program and LTCH providers are currently collecting and submitting data on measures specified by CMS. LTCHs that fail to successfully participate in the LTCHQR Program receive reduced payments through a reduction of 2.0 percentage points to the LTCH marketbasket update. CMS will make these payment determinations each year beginning with FFY 2014.


CMS used the FFY 2014 rulemaking process to revise data submission timelines for previously adopted measures that will be used for FFY 2016 payment determinations. CMS is also adopting new measures and updates for FFYs 2017 and 2018 LTCHQR Program payment determinations.

For FFY 2017 payment determinations, CMS finalized its proposal to collect data on a total of 8 measures. CMS will retain 5 measures currently in place/newly adopted and add the following 3 measures:

- National Healthcare Safety Network (NHSN) facility-wide inpatient hospital-onset Methicillin-Resistant Staphylococcus aureus (MRSA) bacteremia outcome measure (National Quality Forum (NQF) #1716);
- NHSN facility-wide inpatient hospital-onset Clostridium difficile Infection (CDI) outcome measure (NQF #1717); and
- All-cause unplanned readmission measure for 30 days post-discharge from LTCHs.
For FFY 2018 payment determinations, CMS finalized its proposal to collect data on a total of 9 measures. CMS will retain the 8 measures currently in place/newly adopted and will add the following measure:

- Application of the percent of residents experiencing one or more falls with major injury (long stay) (NQF #0674)

Complete detail on the adopted LTCHQR Program data submission methods and timeframes for FFYs 2017 and 2018 payment determinations are provided in the FR pages referenced above.

CMS is also adopting its proposal for a waiver process to recognize the effect that natural disasters might have on a LTCH’s ability to collect and submit quality data. Under the adopted process, a LTCH will be required to submit a waiver request within 30 days of the date that the extraordinary circumstance occurred. CMS also adopted its proposal for a LTCH Quality Reporting appeals and reconsideration process for FFY 2015 and future reporting years’ payment determinations.

**Future Payment Refinement under the LTCH PPS**

*FR pages 50,772-50,774*

CMS used the FFY 2014 rulemaking process to describe plans to pursue payment refinement under the LTCH PPS during next year’s rulemaking process (FFY 2015). CMS used the proposed rule to review the past work MedPAC and the current work of its contractors on defining and targeting Medicare patients and services that are most appropriate for payment under the LTCH PPS. Ultimately, these refinements would likely continue to pay a form of the current the LTCH PPS payment amount for patients defined by CMS to be LTCH-appropriate and a lesser amount for all other patients. A detailed description of the types of payment refinement CMS is considering is available on FR pages 27,668-27,676 of the 2014 LTCH PPS proposed rule. CMS solicited industry comment on this issue in the proposed rule and did not directly address the comments they received in the final rule. Rather, CMS made clarifications to the potential payment refinements reviewed in the proposed rule and plans to share industry comments with its contractors.

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