Medicare Long-Term Care Hospital
Prospective Payment System

Payment Rule Brief — PROPOSED RULE
Program Year: FFY 2015

Overview, Resources, and Comment Submission

On May 15, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2015 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 based on regulatory changes put forward by CMS and legislative changes previously adopted by Congress.

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

An online version of the rule is available at https://federalregister.gov/a/2014-10067.

A brief of the proposed rule is provided below along with FR page references for additional details. Program changes adopted by CMS would be effective for discharges on or after October 1, 2014 unless otherwise noted. Comments on the proposed rule are due to CMS by Monday, June 30 and can be submitted electronically at http://www.regulations.gov by using the website’s search feature to search for file code “1607-P.”

Effect of BiBA and PAMA on the LTCH PPS
FR pages 28,194-28,206

The Bipartisan Budget Act (BiBA) of 2013 and Protecting Access to Medicare Act (PAMA) of 2014 included several significant provisions related to current and future LTCH PPS policies and payment. The following is a brief summary of the mandates:

- Site Neutral Payments (FR pages 28,204-28,206): BiPA mandates the use of “site neutral” Inpatient Prospective Payment System (IPPS) equivalent payment rates for LTCHs beginning FFY 2016 (with a one-year phase-in) unless newly specified criteria are met. CMS is not putting forward proposals related to the BiPA mandates this year. Instead, CMS, citing the degree of the forthcoming changes, is seeking industry feedback to inform next year’s proposals.

The law establishes the following patient-level clinical criteria in order for the standard LTCH PPS payment to be made:

- the stay in the LTCH is immediately preceded by a discharge from an acute care hospital that included at least 3 days in an intensive care unit (ICU); or the stay in the LTCH is immediately preceded by a discharge from an acute care hospital and the patient’s LTCH stay was assigned to an Medicare Severity-Long-Term Care-Diagnosis Related Group (MS-LTC-DRG) based on the receipt of ventilator services of at least 96 hours; and

- the LTCH discharge does not have a principal diagnosis relating to a psychiatric diagnosis or to rehabilitation.

In addition, BiPA mandates an IPPS equivalent payment rate for ALL discharges for LTCHs that fail to meet the applicable discharge threshold (less than 50% of patients for whom the standard LTCH PPS payment is
made). This mandate would be effective for discharges occurring in cost reporting periods during or after FFY 2021. The law includes a reinstatement process for LTCHs that fail to meet the required discharge threshold percentage in a particular year.

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

- **25% Payment Adjustment Threshold (FR pages 28,194-28,195):** Since 2005, legislative and regulatory action has delayed full application of the 25% payment adjustment threshold for most LTCHs. This policy would 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. BiBA further delays implementation of this policy through cost reporting periods that begin on or after July 1, or October 1, 2016 depending on LTCH type. Certain “grandfathered” LTCHs are now permanently exempted from the policy by law.

- **Restrictions on the Establishment/Classification of New LTCHs and Bed Growth at LTCHs (FR pages 28,198-28,200):** Since 2007, Congress has restricted the establishment/classification of new LTCHs/LTCH satellites and bed growth at existing LTCHs/LTCH satellites. BiPA and PAMA extend these restrictions through September 30, 2017 with some exceptions for the establishment of new LTCHs.

**LTCH Payment Rate**

*FR pages 28,187-28,189 and 28,333-28,334*

Incorporating the proposed updates and the effects of a budget neutrality adjustment, the table below lists the full LTCH standard federal rate for FFY 2015 compared to the rate currently in effect:

<table>
<thead>
<tr>
<th>LTCH Standard Federal Rate</th>
<th>Final FFY 2014</th>
<th>Proposed FFY 2015</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>$40,607.31</td>
<td>$40,943.51</td>
<td>+0.8%</td>
<td></td>
</tr>
</tbody>
</table>

The table below provides details of the proposed updates for the LTCH standard federal rate for FFY 2015:

<table>
<thead>
<tr>
<th>Proposed LTCH Rate Updates</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marketbasket (MB) Update</td>
<td>+2.1%</td>
</tr>
<tr>
<td>Full MB update of 2.7% minus Affordable Care Act (ACA)-mandated 0.4% productivity reduction and 0.2% pre-determined reduction</td>
<td></td>
</tr>
<tr>
<td>Prospective Budget Neutrality Adjustment Reduction</td>
<td>-1.266%</td>
</tr>
<tr>
<td>Wage Index Budget Neutrality Adjustment</td>
<td>+0.02034%</td>
</tr>
<tr>
<td><strong>Overall Rate Change</strong></td>
<td>+0.8%</td>
</tr>
</tbody>
</table>

**Prospective Budget Neutrality Adjustment Reduction**

*FR pages 28,189-28,190*

Since the implementation of the LTCH PPS in FFY 2003, CMS has maintained that it has the statutory authority to apply a prospective (permanent) reduction to the LTCH standard rate in order to neutralize for any increase in aggregate payments that may have occurred as a result of transitioning LTCHs from a cost-based payment system to a PPS. CMS believes that the transition to the PPS in FFY 2003 increased aggregate payments to LTCHs by 3.75%. CMS first suggested applying budget neutrality adjustment reductions to the standard rate in
2007, but legislative moratoria prevented CMS from implementing such reductions until FFY 2013. In both FFYs 2013 and 2014, CMS applied a -1.266% adjustment to the LTCH rate to phase-in the 3.75% reduction to payments the agency deemed necessary due to the PPS transition. For FFY 2015, CMS is proposing to apply another -1.266% adjustment to the rate to fully achieve the 3.75% reduction. Future prospective budget neutrality adjustment reductions are not anticipated under the LTCH PPS.

**Effect of Sequestration**

*FR page reference not available*

While the proposed rule does not specifically address the 2.0% sequester reductions to all lines of Medicare payments authorized by Congress and currently in effect through FFY 2024, sequester will continue unless Congress intervenes. Sequester is not applied to the payment rate; instead, it is applied to Medicare claims after determining co-insurance, any applicable deductibles, and any applicable Medicare secondary payment adjustments.

**Wage Index, Labor-Related Share, and COLA**

*FR pages 28,193-28,194 and 28,334-28,339*

For FFY 2015, CMS is proposing updates to the CBSA delineations, the labor-markets that define a LTCH’s Medicare wage index. Beyond the CBSA changes, CMS is not proposing any major changes to the standard calculation of wage index for LTCHs. As has been the case in prior years, CMS would use the most recent inpatient hospital wage index, the FFY 2015 pre-rural floor and pre-reclassified hospital wage index, to adjust payment rates under the LTCH PPS for FFY 2015. CMS is not proposing any changes to the cost-of-living adjustments applicable to LTCHs in Alaska and Hawaii.

CMS’ proposed changes to the CBSA delineations would have a direct impact on the Medicare wage index used for payment purposes under the LTCH PPS. CMS last updated the CBSA delineations in 2005 (based on the 2000 Census). The CBSA changes proposed for FFY 2015 (based on the 2010 Census) are not as substantial as those made in 2005 in terms of changes in the geographic make-up of the labor-market areas. However, under the new delineations there would be:

- newly created CBSAs;
- urban counties that would become rural;
- rural counties that would become urban; and
- existing CBSAs that would be split apart or incorporate additional counties.

The proposed CBSA changes would have both positive and negative impacts on LTCH payments. To mitigate the negative impacts, CMS is proposing a 1-year transitional wage index for ANY LTCH that experiences a wage index reduction due solely to the new CBSA delineations (estimated to be about 60 LTCHs). The transition value would be for FFY 2015 only, using FFY 2015 wage data, with 50% based on the current CBSA delineations and 50% based on the new CBSA delineations. The transitional wage index would expire for FFY 2016. At that point, the wage index values would be fully based on the new CBSA delineations.

The wage index, which is used to adjustment 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. For FFY 2015, CMS is proposing to increase the labor-related share from 62.537% for FFY 2014 to 62.571% for FFY 2015. This change would provide a slight increase in payments to LTCHs with a wage index greater than 1.0.

A complete list of the proposed wage indexes to be used for payment in FFY 2015 along with a comparison of wage index values under the old and new CBSA delineations is available in Tables 12A-12D on the CMS website at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/LTCPPS-Regulations-and-Notices-Items/LTCH-PPS-CMS-1607-P.html?DLPage=1&DLSort=3&DLSortDir=descending](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/LTCPPS-Regulations-and-Notices-Items/LTCH-PPS-CMS-1607-P.html?DLPage=1&DLSort=3&DLSortDir=descending).
Updates to the MS-LTC-DRGs  
*FR pages 28,179-28,186*

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 identical to those used under the inpatient PPS, the relative weights are different for each setting. CMS is not proposing any major changes to the way the MS-LTC-DRG payment weights are calculated for FFY 2015. As proposed, when compared to the weights currently in effect, the weights for the top 50 utilized MS-LTC-DRGs (80% of cases) would change on average by -0.58% (with a range of up to -5.2% and +8.7%). The proposed FFY 2015 MS-LTC-DRGs and weights are available in Table 11 on the CMS website at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/LTCHPPS-Regulations-and-Notices-Items/LTCH-PPS-CMS-1607-P.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-1607-P.html?DLPage=1&DLSort=3&DLSortDir=descending).

HCO Payments  
*FR pages 28,338-28,341*

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 is proposing to increase the fixed-loss amount by 18.1% from $13,314 in FFY 2014 to $15,730 in FFY 2015.

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 is not proposing any major changes to the SSO policy for FFY 2015. Payments for SSO cases would 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
4) Depending on the LOS of the SSO case relative to the “IPPS comparable threshold”: 100% of the comparable inpatient PPS (IPPS) 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 IPPS.

Updates to the LTCHQR Program  
*FR pages 28,259-28,278*

As previously adopted, for FFY 2015 payment determinations under the Long-Term Care Hospital Quality Reporting (LTCHQR) Program, hospitals were required to report on a total of 3 quality measures. CMS has already adopted additional measures though the FFY 2018 payment determination year. LTCHs that do not
successfully participate in the LTCHQR Program are subject to a 2.0 percentage point reduction to the marketbasket update for the applicable year—this reduction value is set in law.

CMS is using the FFY 2015 rulemaking process to propose new measures for FFY 2018 payment determinations along with updated and/or new data submission timelines for the previously adopted and newly proposed measures.

For FFY 2018 payment determinations, CMS is proposing to collect data on a total of 12 quality measures (up from 8 measures for FFY 2017 determinations). CMS is proposing to retain the 9 measures currently in place for FFY 2018 determinations and add 3 new measures (2 functional status measures and 1 outcomes measure). The following lists the LTCHQR Program measures and applicable payment determination years:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Payment Determination Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF #0138: NHSN Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure</td>
<td>FFY 2015 and beyond</td>
</tr>
<tr>
<td>NQF #0139: NHSN Central Line-Associated Blood Stream Infection (CLABSI) Outcome Measure</td>
<td>FFY 2015 and beyond</td>
</tr>
<tr>
<td>NQF #0678: Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay)</td>
<td>FFY 2015 and beyond</td>
</tr>
<tr>
<td>NQF #0680: Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay)</td>
<td>FFY 2016 and beyond</td>
</tr>
<tr>
<td>NQF #0431: Influenza Vaccination Coverage among Healthcare Personnel</td>
<td>FFY 2016 and beyond</td>
</tr>
<tr>
<td>NQF #1716: NHSN Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure</td>
<td>FFY 2017 and beyond</td>
</tr>
<tr>
<td>NQF #1717: NHSN Facility-Wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure</td>
<td>FFY 2017 and beyond</td>
</tr>
<tr>
<td>NQF #2512–Review Pending: All-cause Unplanned Readmission Measure for 30 Days Post-Discharge from Long-Term Care Hospitals FY 2017 and Subsequent</td>
<td>FFY 2017 and beyond</td>
</tr>
<tr>
<td>Application of NQF #0674: Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay)</td>
<td>FFY 2018 and beyond</td>
</tr>
<tr>
<td>[Not NQF Endorsed]: Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function</td>
<td>FFY 2018 and beyond (newly proposed)</td>
</tr>
<tr>
<td>[Not NQF Endorsed]: Change in Mobility among Patients Requiring Ventilator Support</td>
<td>FFY 2018 and beyond (newly proposed)</td>
</tr>
<tr>
<td>[Not NQF Endorsed]: NHSN Ventilator-Associated Event (VAE) Outcome Measure</td>
<td>FFY 2018 and beyond (newly proposed)</td>
</tr>
</tbody>
</table>

As it does each year, CMS is using the proposed rule to update the LTCHQR Program data submission deadlines and procedures, data validation requirements and methods, and other program details. CMS is also seeking comment on future measure topics and the future use of electronic health records (EHRs) to collect LTCH quality data. Complete detail on these items is available on FR pages 28,268-28,278.

**Interrupted Stay Policy**

*FR pages 28,195-28,198*

Under the LTCH PPS, an “interrupted stay” occurs when a patient is discharged from an LTCH—to an acute care hospital, Inpatient Rehabilitation Facility (IRF), or Skilled Nursing Facility (SNF) for treatment/services not available in the LTCH—and subsequently readmitted to the same LTCH for continued treatment. When an interrupted stay occurs, the LTCH is paid a single payment for both stays. CMS maintains both a “3-day or less interrupted stay” policy and a “greater than 3-day interruption of stay” policy. CMS is proposing a new 30-day standard as the fixed-day threshold under “greater than 3-day interruption of stay” policy. The current policy has a variable-day standard based on the type of provider to which the patient is discharged to/readmitted.
from (acute care hospital [9 day threshold], IRF [27 day threshold], or SNF [45 day threshold]). According to CMS, the proposed change is an effort to make consistent the readmissions intervals evaluated under the LTCH interrupted stay policy, the Hospital Readmissions Reduction Program and the Hospital Inpatient Quality Reporting (IQR) Program. In conjunction with the interrupted stay proposal, CMS is proposing to eliminate the 5% readmissions policy. This policy makes one LTCH payment for ALL interrupted stays if the number of discharges and readmissions between an LTCH and a co-located provider exceeds 5% of the total discharges during a cost reporting period.

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