Medicare Long-Term Care Hospital Prospective Payment System

Payment Rule Brief — PROPOSED RULE  
Program Year: FFY 2016

Overview, Resources, and Comment Submission

On May 17, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2016 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, including the implementation of site neutral payments.

A copy of the proposed rule Federal Register (FR) and other resources related to the LTCH PPS are available on the CMS website at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Proposed-Rule-Home-Page.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Proposed-Rule-Home-Page.html).

An online version of the rule is available at [https://federalregister.gov/a/2015-09245](https://federalregister.gov/a/2015-09245).

Program changes adopted by CMS would be effective for discharges on or after October 1, 2015 unless otherwise noted. Comments on the proposed rule are due to CMS by June 16 and can be submitted electronically at [http://www.regulations.gov](http://www.regulations.gov) by using the website’s search feature to search for file code “1632-P.”

LTCH Payment Rate

*FR pages 24,550-24,553 and 24,641-24,650*

Incorporating the proposed updates and the effects of a budget neutrality adjustment, the table below lists the full LTCH standard federal rate for FFY 2016 compared to the rate currently in effect:

<table>
<thead>
<tr>
<th>LTCH Standard Federal Rate</th>
<th>Final FFY 2015</th>
<th>Proposed FFY 2016</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTCH Standard Federal Rate</td>
<td>$41,043.71</td>
<td>$41,883.93</td>
<td>+2.05%</td>
</tr>
</tbody>
</table>

Cases that qualify for the standard LTCH PPS payment rate will see an increase in that payment rate of 2.05 percent. The table below provides details of the proposed updates for the LTCH standard federal rate for FFY 2016:

<table>
<thead>
<tr>
<th>Proposed LTCH Rate Updates</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Marketbasket (MB) Update</td>
<td>+1.9%</td>
</tr>
<tr>
<td>Full MB update of 2.7% minus Affordable Care Act (ACA)-mandated 0.6% productivity reduction and 0.2% pre-determined reduction</td>
<td></td>
</tr>
<tr>
<td>Wage Index Budget Neutrality Adjustment</td>
<td>+0.1444%</td>
</tr>
<tr>
<td>Overall Rate Change</td>
<td>+2.0444%</td>
</tr>
</tbody>
</table>
Effect of BiBA and PAMA on the LTCH PPS

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 law directs CMS to establish two different types of LTCH PPS payment rates depending on whether or not the patient meets certain clinical criteria: standard LTCH PPS payment rates, and new, lower site neutral LTCH PPS payment rates that are generally based on the IPPS rates including adjustments for teaching hospitals and hospitals serving a disproportionate share of low-income patients. In particular, CMS proposes to implement the statutory transitional payment method for site neutral payment rate cases occurring in cost reporting periods beginning during FFYs 2016 and 2017. For those cases, the applicable payment rate will be calculated as a 50/50 blend of the standard LTCH PPS payment rate and the site neutral payment rate. In the proposed rule, CMS is proposing specifics of the implementation of this statutory requirement.

CMS projects that LTCH PPS payments would decrease by 4.6 percent from FFY 2015, or approximately $250 million, based on the proposed payment rates for FY 2016. This projected decrease is primarily attributable to the Proposed Rule’s implementation of section 1206 of the Pathway for SGR Reform Act of 2013. The law directs CMS to establish two distinct payment groups for LTCH discharges occurring in cost reporting periods beginning on or after October 1, 2015: discharges meeting certain clinical criteria will be paid under the standard LTCH PPS payment rates, and all other patient discharges will be paid under the new, lower “site neutral” payment rates that are generally based on the IPPS rates.

The following is a brief summary of the mandates:

- **Site Neutral Payments (FR pages 24,527-24,529):** BiBA 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).

  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, BiBA 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, BiBA mandates the exclusion of cases paid at the site neutral rate and those paid by Medicare Advantage.

- **25% Payment Adjustment Threshold (FR pages 24,337-24,338):** 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 24,332-24,323]): Since 2007, Congress has restricted the establishment/classification of new LTCHs/LTCH satellites and bed growth at existing LTCHs/LTCH satellites. BiBA and PAMA extend these restrictions through September 30, 2017 with some exceptions for the establishment of new LTCHs.

**Prospective Budget Neutrality Adjustment Reduction**

*FR page reference not available*

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%. In FFYs 2013, 2014, and 2015 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. There are no additional prospective budget neutrality adjustment reductions proposed in FFY 2016.

**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 24,643-24,645*

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 2016 pre-rural floor and pre-reclassified hospital wage index, to adjust payment rates under the LTCH PPS for FFY 2016. CMS is not proposing any changes to the cost-of-living adjustments applicable to LTCHs in Alaska and Hawaii.

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. For FFY 2016, CMS is proposing to increase the labor-related share from 62.306% for FFY 2014 to 62.2% for FFY 2016.

**Updates to the MS-LTC-DRGs**

*FR pages 24,541-24,550*

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 2016, except in this proposed rule, CMS is proposing that the FY 2016 MS–LTC DRG relative weights would be determined based only on data from applicable LTCH cases.
CMS is proposing to use the ICD–10 MS–LTC–DRGs Version 33 beginning October 1, 2015. CMS is inviting public comments on how well the ICD–10 MS–LTC–DRGs Version 33 replicates the logic of the ICD–9 MS–LTC–DRGs Version 32.

Outlier Payments

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 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 proposed the use of two different HCO targets and fixed loss threshold; maintaining a target of 8.0% for cases paid under the LTCH standard Federal payment rate cases and 5.1% for cases paid under the site neutral payment rate which mirrors the target for the IPPS. The fixed-loss threshold for cases paid under the site neutral payment rate will be the same as the fixed-loss threshold in the IPPS which is $24,485; the threshold for cases paid under the LTCH standard Federal payment rate will increase from $14,972 for FFY 215 to $18,768 for FFY 2016. This increase for cases paid under the LTCH standard Federal payment rate is largely to account for the current estimate that HCO payments for FFY 2015 will exceed the target of 8.0% by 0.6%.

Updates to the LTCHQR Program

Beginning in FFY 2014, the applicable annual update for any LTCH that does not submit the required data to CMS is reduced by two percentage points. The IMPACT Act of 2014 requires the specification of quality measures for the LTCH QRP, including such areas as medication reconciliation, skin integrity, functional status, such as mobility and self-care, as well as incidence of major falls. Also the IMPACT Act stipulates that measures must be standardized so they can be applied across postacute care settings.

The following lists the LTCHQR Program measures and applicable payment determination years. The proposed rule focuses initially on measures that can achieve the standardization across settings over time, and minimize or avoid duplication of existing assessment items. At this time, CMS is not proposing any additional LTCH QRP quality measures for the FY 2019 payment determination and subsequent years.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Proposed Cross-Setting Measure</th>
<th>Payment Determination Year</th>
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<tbody>
<tr>
<td>NQF #0138: NHSN Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure</td>
<td>FFY 2015 and beyond</td>
<td></td>
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<tr>
<td>NQF #0139: NHSN Central Line-Associated Blood Stream Infection (CLABSI) Outcome Measure</td>
<td>FFY 2015 and beyond</td>
<td></td>
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<tr>
<td>NQF #0678: Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay)</td>
<td>Yes FFY 2015 and beyond</td>
<td></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>
<td></td>
</tr>
<tr>
<td>NQF #0431: Influenza Vaccination Coverage among Healthcare Personnel</td>
<td>FFY 2016 and beyond</td>
<td></td>
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</tbody>
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NQF #1716: NHSN Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure | FFY 2017 and beyond
NQF #1717: NHSN Facility-Wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure | FFY 2017 and beyond
NQF #2512–Review Pending: All-cause Unplanned Readmission Measure for 30 Days Post-Discharge from Long-Term Care Hospitals FY 2017 and Subsequent | Yes FFY 2017 and beyond
Application of NQF #0674: Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay) | FFY 2018 and beyond
NQF #2631 [Under review at NQF]: Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function | FFY 2018 and beyond
NQF #2632 [Under review at NQF]: Change in Mobility among Patients Requiring Ventilator Support | FFY 2018 and beyond
[Not NQF Endorsed]: NHSN Ventilator-Associated Event (VAE) Outcome Measure | FFY 2018 and beyond

CMS proposes to begin publicly reporting LTCH quality data on a CMS website, such as Hospital Compare by the Fall 2016. CMS is proposing to lengthen the quarterly data submission deadlines from 45 days to 135 days beyond the end of each calendar year quarter beginning with quarter four (4) 2015 quality data in order to align with other quality reporting programs, and to allow an appropriate amount of time for LTCHs to review and correct quality data prior to the public posting of that data.

Future Measure Concepts Under Consideration for the LTCH QRP
FR Page 24,605

The following measures are under consideration (those with an * are cross-setting measures):
- **Patient Safety:** Ventilator Weaning (Liberation) Rate; Compliance with ventilator process Elements during LTCH Stay; Venous Thromboembolism Prophylaxis; Medication Reconciliation.*;
- **Effective Communication and Coordination of Care:** Transfer of health information and care preferences when an individual transitions.; All-Condition Risk-Adjusted Potentially Preventable Hospital Readmission Rate.*;
- **Patient- and Caregiver-Centered Care:** Discharge to community.; Patient Experience of Care; Percent of Patients with Moderate to Severe Pain; Advance Care Plan;
- **Affordable Care:** Medicare Spending per Beneficiary.*

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 24,605-24,615.

Interrupted Stay Policy
FR pages 24,529-24,530

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 is not proposing to make any changes to the interrupted stay policy.