Medicare Long-Term Care Hospital Prospective Payment System

Final Payment Rule Brief provided by the Wisconsin Hospital Association
FFY 2018

Overview and Resources

On August 14, 2017 the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2018 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.

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.

A copy of the final rule is available at https://federalregister.gov/a/2017-16434.

A brief of the final rule is provided below along with page references for additional details. Program changes adopted by CMS will be effective for discharges on or after October 1, 2017 unless otherwise noted.

LTCH Payment Rate

FR pages 38310 – 38312, 38536 - 38537

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.

The two-year transition for the site-neutral payment rate in which site-neutral cases were paid a 50/50 blend of the site-neutral rate and LTCH payment rate has concluded. For FFY 2018, site-neutral LTCH PPS cases will be paid fully under the site-neutral payment rate.

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.

In addition, IPPS equivalent payment rate will be mandated 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, cases paid at the site neutral rate and those paid by Medicare Advantage are excluded.

The Medicare Access and CHIP Reauthorization Act (MACRA) mandated the annual marketbasket update factor for FFY 2018, after all ACA-mandated adjustments, will be 1 percent.

Incorporating the final updates and the effects of budget neutrality adjustments, the table below lists the full LTCH standard federal rate adopted for FFY 2018 compared to the rate currently in effect:

	Final FFY 2017	Final FFY 2018	Percent Change
LTCH Standard Federal Rate	**$42,476.41**	**$41,430.56** (proposed at $41,497.20)	**-2.46%** (proposed at -2.3%)

The table below provides details of the final updates for the LTCH standard federal rate for FFY 2018:

	Final LTCH Rate Updates and Budget Neutrality Adjustments
Marketbasket Update	**+2.7%** (proposed at +2.8%)
Affordable Care Act (ACA)-Mandated Productivity Reduction	**-0.6 percentage points** (proposed at -0.4 percentage points)
ACA Pre-Determined Reduction	**-0.75 percentage points** (as proposed)
MACRA Mandated 1.0% Marketbasket Update	**-0.35%** (proposed at -0.64%)
Wage Index Budget Neutrality Adjustment	**1.0006434** (proposed at 1.000077)
Budget Neutrality Adjustment (as a result of Short Stay Outlier Methodology Change)	**0.9651** (proposed at 0.9672)
Overall Rate Change	**-2.46%** (proposed at -2.3%)

Temporary Site Neutral Payment Rate Exceptions

FR pages 38316 - 38318

The 21st Century Cures Act has implemented temporary exceptions to the site neutral payment rate for certain spinal cord specialty hospitals as well as certain discharges with severe wounds from certain LTCHs.

For spinal cord specialty LTCHs that meet the specified criteria listed below, discharges beginning in FFYs 2018 and 2019 are exempt from the site neutral payment rate and all discharges will be paid at the LTCH PPS standard Federal rate. In order for a spinal cord specialty LTCH to qualify for this exception, the LTCH must:

- Have been a not-for-profit LTCH since June 1, 2014;
- Have at least 50 percent of 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 during FFY 2014 who had been admitted from at least 20 of the 50 states.

For certain discharges with severe wounds, CMS finalized that discharges beginning in FFY 2018 be exempt from the site neutral payment rate and paid at the LTCH PPS standard Federal rate.

In order for a discharge with severe wounds to be excluded from the site neutral payment rate, the discharge must be:

- From hospitals-within-hospitals (HwHs) that were participating in Medicare, but excluded from the hospital IPPS on or before September 30, 1995;
- Classified under MS-LTC-DRG 602, 603, 539, or 540; and
- With respect to an individual treated by an LTCH, for a severe wound, defined as a wound which is a stage 3 wound, stage 4 wound, unstageable wound, non-healing surgical wound, or fistula.

The severe wound exception to the site-neutral payment policy was originally temporarily implemented in an interim final rule on April 21, 2016 and finalized in the FFY 2017 final rule. CMS is implementing this "new" temporary exception for discharges for the treatment of severe wounds using the same list of ICD-10-CM codes.

Revision to Bed Increase Suspension

FR pages 38320 - 38321

The Protecting Access to Medicare Act of 2014 (PAMA) established a suspension of the establishment of new LTCHs and on the increase in the number of hospital beds in existing LTCHs, effective April 1, 2014 through September 30, 2017. The 21st Century Cures Act modified this allowing all existing LTCHs and satellites to increase their beds if they meet qualifying criteria.

Change to Average Length of Stay Criterion

FR page 38321

Currently, in order for a hospital to be classified as an LTCH, the hospital has to maintain an average length of stay of greater than 25 days, excluding Medicare Advantage and site neutral cases from the calculation that were classified as LTCHs as of December 10, 2013. CMS is extending the exclusion of Medicare Advantage and site neutral cases from this length of stay calculation for all LTCHs, for discharges occurring in cost report periods beginning on or after October 1, 2015.

Subclause II LTCH

FR pages 38321 - 38322

When LTCHs were initially defined, two categories of LTCHs were referred to as "subclause (I)" and "subclause (II)". Subclause (I) LTCHs were required to have an average inpatient length of stay that is greater than 25 days, while subclause (II) LTCHs were only required to have an average inpatient length of stay of greater than 20 days. The subclause (II) LTCH definition also required that the LTCH was first excluded from the IPPS in 1986 and is a neoplastic disease hospital. In the FFY 2017 final rule, CMS had finalized that subclause (II) LTCHs would be treated the same as IPPS-excluded hospitals paid under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) payment system to limit charges to beneficiaries and related billing requirements.

In accordance with the 21st Century Cures Act, CMS is sunsetting the subclause (II) LTCH designation and reclassifying these hospitals as "extended neoplastic disease care hospitals" (proposed as "long-term care neoplastic disease hospitals").

Co-Located LTCH Separateness Criteria

FR pages 38292 – 38294, 38571

In 1994 CMS defined a co-located hospital as a hospital that occupies space in a building also used by another hospital or in one or more separate buildings located on the same campus as buildings used by another hospital. CMS required LTCHs as co-located hospitals to have a separate governing body, a chief medical officer, medical staff, and a chief executive officer from that of the hospital with which it is co-located. The LTCH must have also met one of the two following "separateness" criteria:

- The LTCH must perform certain specified basic hospital functions on its own and not receive them from the host hospital or a third entity that controls both hospitals;
- The LTCH must receive at least 75 percent of its inpatients from sources other than the co-located hospital; or
- The cost of the services that the hospital obtains under contracts or other agreements with the co-located hospital or a third entity that controls both hospitals is no more than 15 percent of the hospital's total inpatient operating cost.

CMS proposed to change the "separateness" criteria to only apply to IPPS-excluded LTCHs that are co-located with IPPS hospitals. The initial purpose of the "separateness" criteria was to address a concern that LTCHs were being used by some IPPS hospitals as way to receive higher payments for a subset of their cases. CMS believes that these criteria are now "sufficiently moderated" and therefore no longer needed. CMS is adopting this proposal, beginning in FFY 2018, with the modification that all co-located hospitals will no longer be required to satisfy all of the criteria in order to maintain their co-located status, instead of just those which are not IPPS-excluded LTCHs co-located with IPPS hospitals.

25-Percent Threshold Policy

FR pages 38318 - 38320

Since 2005, legislative and regulatory action has delayed full application of the 25% payment adjustment threshold for most LTCHs. The 25% threshold policy is a per discharge payment adjustment in the LTCH PPS that reduces 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. Certain grandfathered LTCHs are permanently exempted from the policy by law.

In order to comply with the full implementation of the current 25% threshold policy, in the FFY 2017 final rule CMS streamlined its regulations regarding the 25% threshold policy and finalized that the policy would apply to all cases discharged on or after October 1, 2016 that occur in cost reporting periods beginning on or after July 1, 2016. The streamlined version includes:

- Rural LTCHs would be subject to a more lenient 50% threshold; and Metropolitan Statistical Area-dominant LTCHs would be subject to a threshold between 25 and 50%. All locations of an LTCH must be rural or located exclusively in an MSA-dominant area in order to quality for this special treatment;
- LTCH cases that were high-cost outliers in the prior hospital stay would not be counted in the numerator, but they would be counted in the denominators of an LTCH's compliance rate; and
- Medicare Advantage cases would continue to be excluded from the calculation.

The rule finalized a detailed plan for payment reductions for cases that exceed a 25% Rule threshold. The applicable percentage threshold would apply to the LTCH as a whole entity rather than independently of any other location of the LTCH. If an LTCH exceeds the applicable threshold during a cost reporting period, payment would be adjusted for discharges in excess of the threshold and discharges not in excess would continue to be unaffected by the policy.

In response to comments to the FFY 2017 rule, CMS implemented a 1-year delay of the 25% rule threshold, in which the 25% threshold policy would not be implemented until October 1, 2018. CMS has now finalized a 12 month extension to this statutory moratorium that will extend the relief through FFY 2018. CMS plans to use

this time to examine the impact of LTCH site-neutral payments to determine whether the 25% rule is still necessary. This extension of the delay of the full application of the 25% threshold policy results in a "gap" period where LTCHs are required to comply with the fully-implemented 25% threshold policy for their cost report periods beginning on or after July 1, 2016 and before October 1, 2016, for any discharges occurring on or before September 30, 2016.

Wage Index, Labor-Related Share, CBSA and COLA

FR pages 38537 - 38540

There are no major changes adopted for the calculation of wage indexes for LTCHs. As has been the case in prior years, CMS is using the most recent inpatient hospital wage index: the FFY 2018 pre-rural floor and pre-reclassified hospital wage index, to adjust payment rates under the LTCH PPS for FFY 2018.

CMS updates the cost-of-living adjustments (COLA) applicable to LTCHs in Alaska and Hawaii every 4 years to account for the higher costs incurred in those States. The COLA factors for Alaska and Hawaii under the LTCH PPS for FFY 2018 are detailed below:

Area	FFY 2013	FFY 2014 - 2017	Adopted FFY 2018
Alaska:			
City of Anchorage and 80-kilometer (50-mile) radius by foot	1.23	1.23	1.25
City of Fairbanks and 80-kilometer (50-mile) radius by foot	1.23	1.23	1.25
City of Juneau and 80-kilometer (50-mile) radius by foot	1.23	1.23	1.25
Rest of Alaska	1.25	1.25	1.25
Hawaii:			
City and County of Honolulu	1.25	1.25	1.25
County of Hawaii	1.18	1.19	1.21
County of Kauai	1.25	1.25	1.25
County of Maui and County of Kalawao	1.25	1.25	1.25

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 2018, CMS is decreasing the labor-related share from 66.5% to 66.2% (proposed at 66.3%). This change will provide an increase in payments to LTCHs with a wage index less than 1.0.

Updates to the MS-LTC-DRGs

FR pages 38301 - 38310

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. 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 using its existing methodology to determine the MS-LTC-DRG relative weights.

HCO Payments

FR pages 38540 - 38546

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 adopted two separate high-cost outlier targets beginning in FFY 2016 – 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 also uses the IPPS fixed loss amount for site neutral cases. Since CMS projected that the current fixed-loss amount would result in high-cost outlier payments that exceed the 8.0% target, CMS is increasing the threshold for cases paid under the LTCH standard Federal payment rate from $21,943 in FFY 2017 to $27,382 (proposed at $30,081) in FFY 2018. The fixed-loss threshold for cases paid under the site neutral payment rate will increase from $23,570 in FFY 2017 to $26,601 (proposed at $26,713) in FFY 2018. This fixed-loss amount for site-neutral payment rate cases is the same as the FFY 2018 IPPS fixed-loss amount.

CMS will continue to make an additional HCO payment for the cost of an LTCH PPS standard Federal payment rate 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 adopted SSO policy) for both LTCH Standard cases and site neutral cases.

SSO Payments

FR pages 38312 – 38316, 38541 - 38544

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 5/6th 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. Currently, SSO cases payments are adjusted to the lower of:

- 100 percent of the estimated cost of the case;
- 120 percent of the MS-LTC-DRG specific per diem amount multiplied by the covered length of stay of that discharge;
- The full MS-LTC-DRG payment amount;
- A blend of the IPPS per diem amount and 120 percent of the MS-LTC-DRG per diem payment amount; or
- An IPPS per diem amount, capped at an amount to not exceed what would have been a full payment under the IPPS.

Because SSO cases are paid the "lesser" of various payment options, while non-SSO cases are paid the full MS-LTC-DRG payment, there is an incentive to hold a patient beyond the SSO threshold in order to increase payment. CMS is therefore replacing the current payment adjustment options with a single blended payment adjustment amount composed of the IPPS per diem amount and 120 percent of the LTCH PPS per diem amount. As the length of stay increases, the amount paid at the IPPS per diem would decrease and the amount paid at 120 percent of the LTCH PPS per diem would increase. The maximum payment would be set to the full LTCH PPS standard Federal payment rate. This blended per diem rate would result in paying LTCH cases with a very short length of stay more like an IPPS case, and LTCH cases with relatively longer lengths-of-stay more like

a non-short-stay LTCH PPS standard Federal payment rate case, removing the financial incentive to hold patients longer.

This will continue to apply only to cases paid under the LTCH PPS standard rate portion of site-neutral cases for cost report periods starting before October 1, 2017, not the site-neutral payment rate. With the new SSO methodology CMS is also finalizing that SSO cases will no longer be subject to reconciliation.

CMS expects this would result in increased payments to SSO cases by 30% or $145 million, assuming no change in LTCHs' discharge behavior under the adopted SSO methodology. However, because the goal of the policy is to remove the incentive to delay patient discharges and not to increase Medicare LTCH PPS payments, CMS is implementing this policy in a budget neutral manner. CMS expects this budget neutral approach to result in minimal redistribution between different LTCHs and therefore for most LTCHs the increase in payments for SSO cases would generally offset any budget-neutral related decreases to non-SSO LTCH PPS payment rate cases. CMS adopted a budget neutrality factor of 0.9651 (proposed at 0.9672) to offset these increased payments.

If a patient is hospitalized for less than $5/6^{th}$ of the geometric average length of stay for a specific MS-LTC-DRG, but still incurs extraordinarily high costs, an LTCH discharge can qualify as a SSO case as well as a HCO case. In the FFY 2017 final rule, CMS finalized that an SSO that is also an HCO case would receive an HCO payment of 80 percent of the difference between the estimated cost of the case and the outlier threshold.

Updates to the LTCH Quality Reporting Program (LTCH QRP)

FR pages 38425 - 38461

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 finalized LTCH QRP measures and applicable payment determination years.

Measure	NQF #	Finalized Cross-Setting Measure	Payment Determination Year
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
Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay)	#0678	Yes	FFY 2018 and beyond
Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay)	#0680		FFY 2016 and beyond
Influenza Vaccination Coverage among Healthcare Personnel	#0431		FFY 2016 and beyond
NHSN Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	#1716		FFY 2017 and beyond
NHSN Facility-Wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure	#1717		FFY 2017 and beyond
All-cause Unplanned Readmission Measure for 30 Days Post-Discharge from Long-Term Care Hospitals	#2512	Yes	FFY 2018 and beyond
Application of Percent of Residents Experiencing One or More Falls	#0674	Yes	FFY 2018 and

with Major Injury (Long-Stay)			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
Change in Mobility among Patients Requiring Ventilator Support	#2632		FFY 2018 and beyond
NHSN Ventilator-Associated Event (VAE) Outcome Measure	N/A		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

CMS is removing two measures from the LTCH QRP:

- Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) (will remain until FFY 2020)
- All-cause Unplanned Readmission Measure for 30 Days Post-Discharge from Long-Term Care Hospitals (NQF #2512)

For purposes of the FFY 2019 LTCH QRP, LTCHs are only be required to submit data on the Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) measure for the last 3 quarters of calendar year 2017.

CMS is adopting three new measures for FFY 2020 and subsequent years:

- Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
- Compliance with Spontaneous Breathing Trial (SBT) by Day 2 of the LTCH Stay
- Ventilator Liberation Rate

LTCHs are only be required to submit data on these measures for the last three quarters of calendar year 2018. Starting in calendar year 2019, LTCHs are required to submit data for the entire year beginning with the FFY 2021 LTCH QRP.

For future years, CMS sought comment on the following measures under consideration for the LTCH QRP:

- Experience of Care
- Application of Percent of Residents Who Self-Report Moderate to Severe Pain (Short Stay)(NQF #0676)
- Advance Care Plan
- Patients Who Received an Antipsychotic Medication
- Modification of the Discharge to Community

A summary of these comments can be found on *FR* pages 38448 – 38449.

To comply with the IMPACT Act, in order to enable access to longitudinal information and to facilitate coordinated care, CMS is requiring that LTCHs begin reporting standardized patient assessment data with respect to five specified patient assessment categories required by law for the FFY 2020 LTCH QRP, including:

- Functional status
- Cognitive function
- Special services, treatments, and interventions
- Medical conditions and comorbidities
- Impairments

Lastly, CMS is adopting additional measures to be publically reported for calendar year 2018 that will would also receive confidential feedback reports from CMS, including:

- Percent of LTCH Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631);
- Application of Percent of Residents Experiencing One or More Falls with Major Injury (NQF #0674)
- Medicare Spending Per Beneficiary- PAC LTCH QRP; and
- Potentially Preventable 30-Day Post-Discharge Readmission Measure for LTCH QRP.

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