Medicare Long-Term Care Hospital Prospective Payment System

Proposed Payment Rule Brief provided by the Wisconsin Hospital Association
Program Year: FFY 2019

Overview and Resources

On April 24, 2018 the Centers for Medicare and Medicaid Services (CMS) released the display copy of the federal fiscal year (FFY) 2018 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.

A display copy of the proposed rule is available at https://www.federalregister.gov/documents/2018/05/07/2018-08705/medicare-programs-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-long.

A brief of the proposed rule is provided below along with page references for additional details. Program changes proposed by CMS will be effective for discharges on or after October 1, 2018 unless otherwise noted. Comments on all aspects of the proposed rule are due to CMS by June 25, 2018 and can be submitted electronically at https://www.regulations.gov/ by using the website's search feature to search for file code "1694-P".

LTCH Payment Rate

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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.

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.

Incorporating the proposed updates and the effects of budget neutrality adjustments, the table below lists the full LTCH standard federal rate proposed for FFY 2019 compared to the rate currently in effect:

	Final FFY 2018	Proposed FFY 2019	Percent Change
LTCH Standard Federal Rate	**$41,415.11**	**$41,482.98**	**0.16%**

The table below provides details of the proposed updates for the LTCH standard federal rate for FFY 2019:

	LTCH Rate Updates and Budget Neutrality Adjustments
Marketbasket Update	**+2.7%**
Affordable Care Act (ACA)-Mandated Productivity Reduction	**-0.8 percentage points**
ACA Pre-Determined Reduction	**-0.75 percentage points**
Wage Index Budget Neutrality Adjustment	**0.999713**
Budget Neutrality Adjustment (as a result of Elimination of 25-percent Threshold)	**0.990535**
Overall Rate Change	**0.16%**

Changes to the Site Neutral Payment Rate

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The original 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. However, the Bipartisan Budget Act of 2018 extended the transitional blended payment rate for site neutral payment rate cases for an additional two years, FFY 2018 and FFY 2019.

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.

25-Percent Threshold Policy

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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 rule finalized a detailed plan for payment reductions for cases that exceed a 25% Rule threshold. 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. In the FFY 2018 final rule, CMS implemented a 12 month extension to this statutory moratorium that extended the relief through FFY 2018.

CMS is proposing the removal of the 25% threshold policy because CMS believes it is no longer an appropriate mechanism to ensure that an LTCH does not act as a step-down unit of an IPPS hospital. This will reduce unnecessary regulatory burden.

If the 25% threshold policy were implemented this year, it would have reduced the LTCH PPS payments for certain discharges. If finalized, this proposal to eliminate the 25% threshold policy would be expected to result in an increase in aggregate LTCH PPS payments. Therefore, CMS is proposing to eliminate the 25% threshold policy in a budget neutral manner. CMS is proposing to apply the budget neutrality adjustment only to the LTCH PPS standard Federal payment rate because payments made under the site neutral payment rate would be unaffected by the policy. However, because of the transitional blend, any adjustment applied to the LTCH PPS standard Federal payment rate would also need to be applied to the LTCH PPS standard Federal rate portion of payments that affect site neutral payment rate cases. CMS is proposing a budget neutrality factor of 0.9905345.

Wage Index Labor-Related Share, CBSA and COLA

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CMS did not proposed any major changes for the calculation of wage indexes for LTCHs. As has been the case in prior years, CMS is proposing to use the most recent inpatient hospital wage index: the FFY 2019 pre-rural floor and pre-reclassified hospital wage index, to adjust payment rates under the LTCH PPS for FFY 2019.

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 2019, CMS is proposing to maintain the labor-related share at 66.2% (same as FFY 2018).

Updates to the MS-LTC-DRGs

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

HCO Payments

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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.

If an LTCH's CCR is higher than the 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 1.28 for FFY 2019 for both LTCH PPS standard Federal payment rate cases and site neutral payment rate cases.

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 proposing to increase the threshold for cases paid under the LTCH standard Federal payment rate from $27,381 in FFY 2018 to $30,639 in FFY 2019. CMS is also proposing that the fixed-loss threshold for cases paid under the site neutral payment rate increase from $26,537 in FFY 2018 to $27,545 in FFY 2019. This proposed fixed-loss amount for site-neutral payment rate cases is the same as the FFY 2019 proposed IPPS fixed-loss amount.

CMS is proposing to 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

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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.

LTCH PPS standard rate SSO cases (including the portion of site neutral cases that are paid at LTCH PPS standard due to the transitional blend) are paid 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.

The SSO policy does not apply to site neutral payment cases.

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)

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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) **(removed after this year)**	#0678	Yes	FFY 2018-FFY 2020
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
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
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
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

CMS is proposing an eighth factor to consider when evaluating measures for removal from the LTCH QRP Program measure set: the costs associated with a measure outweigh the benefit of its continued use in the program.

CMS is proposing to remove two measures from the LTCH QRP beginning FFY 2020:

- National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716)
- NHSN Ventilator-Associated Event (VAE) Outcome Measure

For the FFY 2021 LTCH QRP, CMS is proposing to remove an additional measure:

- Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680)

In addition, CMS is soliciting comment on whether they should move the implementation of any new version of the LTCH CARE Data from the usual release date of April to October in the future.

Currently, CMS notifies an LTCH of noncompliance with the LTCH QRP requirements using the QIES ASAP system only. CMS is proposing to notify LTCHs of noncompliance with the LTCH QRP requirements via a letter sent through at least once of the following methods: the QIES ASAP system, the United States Postal Service, or via an email from the Medicare Administrative Contractor (MAC).

CMS is also considering options to improve health disparities among patient groups within and across hospitals by increasing transparency of disparities through quality measures and quality programs.

CMS Request for Information (RFI)

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With this proposed rule, CMS is issuing an RFI on "Promoting Interoperability and Electronic Healthcare Information Exchange through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare- and Medicaid- Participating Providers and Suppliers." This RFI is to solicit feedback on positive solutions to better achieve interoperability on the sharing of healthcare data between providers. Submissions will be considered in developing future regulatory proposals or sub-regulatory guidance.

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