Medicare Long-Term Care Hospital
Prospective Payment System

August 22, 2016

Payment Rule Brief — FINAL RULE
Program Year: FFY 2017

Overview and Resources

On August 2, 2016 the Centers for Medicare and Medicaid Services (CMS) released the display copy of the federal fiscal year (FFY) 2017 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 display copy of the final rule Federal Register (FR) and other 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.

An online version of the final rule will be available on August 22nd, 2016 at https://federalregister.gov/a/2016-18476.

A brief of the final rule is provided below along with display copy page references for additional details. Program changes adopted by CMS will be effective for discharges on or after October 1, 2016 unless otherwise noted.

Effect of BiBA and PAMA on the LTCH PPS
DISPLAY pages 1276-1280

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 laws direct CMS to establish two different types of LTCH PPS payment rates: the standard LTCH PPS payment rates and site-neutral LTCH PPS payment rates, which are based on the IPPS rates. LTCH discharges that meet certain clinical criteria (detailed below) will continue to be paid at the standard LTCH PPS payment rates. LTCH discharges from that do not meet the established clinical criteria will be paid the new, lower site-neutral payment rates (with some specified exclusions). In last year’s FFY 2016 LTCH final rule, CMS implemented a two-year transition for the site-neutral payment rates, beginning with cost reporting periods that started on or after October 1, 2015. For the first year of the transition, site-neutral payments are based on a 50/50 blend of LTCH PPS standard Federal payment rate and the LTCH PPS site neutral payment rate. FFY 2017 will be the second year of the 50/50 site-neutral transition for impacted cases.

The following is a brief summary of the mandates:
Site Neutral Payments: BiBA mandates the use of “site-neutral” Inpatient Prospective Payment System (IPPS) equivalent payment rates for LTCHs beginning FFY 2016 (with a two-year phase-in).

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.

As 2017 is the second year of the transition, site-neutral cases will be paid a 50-50 blend of the standard LTCH PPS rate and the applicable site-neutral rate. All applicable adjustments would apply to each of the rates contributing to the blended payment. Following this transition period, site-neutral cases would be paid fully under the site-neutral rates.

CMS finalized that the site neutral payment rate is the lesser of either the IPPS comparable per diem amount, 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.

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 (Display pages 1421 - 1450): Since 2005, legislative and regulatory action has delayed full application of the 25% payment adjustment threshold for most LTCHs. This policy will 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. Certain grandfathered LTCHs are permanently exempted from the policy by law. The 25% threshold policy will be applied to site-neutral payment rate cases and standard payment LTCH cases. CMS is streamlining its regulations regarding the 25 percent threshold policy. CMS proposed the policy to apply to all cases discharged on or after October 1, 2016. However, in order to comply with the full implementation of the current 25% threshold policy, CMS is revising the policy to 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 qualify 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 compliance calculation.
The rule finalizes 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.

**Rebasing of Market Basket**

*DISPLAY pages 1355 - 1387*

CMS will revise and rebase the market basket used under the LTCH PPS (currently the 2009-based LTCH-specific market basket) to reflect a 2013 base year.

**LTCH Payment Rate**

*DISPLAY pages 1397 - 1421, 2223 - 2231*

Incorporating the final updates and the effects of a budget neutrality adjustment, the table below lists the full LTCH standard federal rate for FFY 2017 compared to the rate currently in effect:

<table>
<thead>
<tr>
<th>LTCH Standard Federal Rate</th>
<th>Final FFY 2016</th>
<th>Final FFY 2017</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$41,762.85</td>
<td>$42,476.41</td>
<td>+1.7% (proposed at +1.3%)</td>
</tr>
</tbody>
</table>

The table below provides details of the final updates for the LTCH standard federal rate for FFY 2017:

<table>
<thead>
<tr>
<th>Final LTCH Rate Updates and Budget Neutrality Adjustments</th>
<th>Marketbasket (MB) Update</th>
<th>Affordable Care Act (ACA) - Mandated Productivity MB Reduction</th>
<th>ACA Pre-determined Reduction</th>
<th>Wage Index Budget Neutrality Adjustment</th>
<th>Overall Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>+2.8% (proposed at +2.7%)</td>
<td>-0.3 percentage points (proposed at -0.5 percentage points)</td>
<td>-0.75 percentage points (proposed at -0.75 percentage points)</td>
<td>0.999593 (proposed at 0.99873)</td>
<td>+1.7% (proposed at +1.3%)</td>
</tr>
</tbody>
</table>

**Subclause II LTCH**

*DISPLAY pages 1450 - 1454*

CMS is finalizing the revision to the limitation on the charges to beneficiaries’ policy and related billing requirements for subclause (II) LTCHs for cost reporting periods beginning on or after October 1, 2016. The adjusted LTCH PPS payment to subclause (II) LTCHs under § 412.526 is considered the full LTCH PPS payment (that is, the LTCH PPS standard Federal payment rate or site neutral payment rate, as applicable), and as such, under current policy that payment applies to the LTCH’s costs for services furnished until the high-cost outlier threshold is met. CMS is revising that for a subclause (II) LTCH, the Medicare payment would only apply to the LTCH’s costs incurred for the days used to calculate the Medicare payment (that is, days for which the patient has a benefit day available).
Furthermore, in addition to the applicable Medicare deductible and coinsurance amounts, CMS is finalizing that the LTCH may only charge the beneficiary for services provided during the stay that were not the basis for the adjusted LTCH PPS payment amount. Therefore, subclause (II) LTCHs will be treated the same as IPPS-excluded hospitals paid under the Tax Equity and Fiscal Responsibility Act of 1982 payment system to limit charges to beneficiaries and related billing requirements.

Wage Index, Labor-Related Share, CBSA and COLA

There are no major changes for the calculation of wage indexes for LTCHs. As has been the case in prior years, CMS would use the most recent inpatient hospital wage index: the FFY 2017 pre-rural floor and pre-reclassified hospital wage index, to adjust payment rates under the LTCH PPS for FFY 2017. CMS did not make 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 2017, CMS is increasing the labor-related share from 62.0% to 66.5% (proposed at 66.6%). This change will provide a decrease in payments to LTCHs with a wage index less than 1.0.

On July 15, 2015, the Office of Management and Budget (OMB) issued revisions to three Core-Based Statistical Areas that will be in effect for FFY 2017 rulemaking:
- Garfield County, OK was classified as geographically rural, now qualifies as the new urban CBSA 21420- Enid, OK.
- The county of Bedford City, VA (SSA code 49088) changed to town status and became a part of Bedford County (SSA code 49090). It remains a part of CBSA 31340- Lynchburg, VA.
- The name of CBSA 31420- Macon, GA has been renamed as Macon-Bibb County, GA.

Updates to the MS-LTC-DRGs

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

HCO 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 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 finalizing the threshold for cases paid under the LTCH standard Federal payment rate to increase from $16,423 in FFY 2016 to $21,943 (proposed at $22,728) in FFY 2017. The fixed-loss threshold for cases paid under the site neutral payment rate will increase from $22,538 in FFY 2016 to $23,570 (proposed at $23,681) in FFY 2017.

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 adjusted LTCH PPS standard Federal payment rate payment and the fixed-loss amount for LTCH PPS standard Federal payment rate cases of $21,943) for both LTCH Standard cases and site neutral cases.

**SSO Payments**

**DISPLAY page 2264**

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.

If a patient is hospitalized for less than 5/6 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 an SSO case as well as an HCO case. CMS is finalizing that beginning FFY 2017, 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)**

**DISPLAY pages 1799 - 1974**

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 IMPACT Act of 2014 requires the specification of quality measures for the LTCH QRP, including such areas as medication reconciliation, skin integrity, functional status, and incidence of major falls. Also the IMPACT Act stipulates that measures must be standardized so they can be applied across post-acute care settings.

The following table lists the LTCH QRP measures and applicable payment determination years. CMS is focusing initially on measures that can achieve standardization across settings over time, and minimize or avoid duplication of existing assessment items.

<table>
<thead>
<tr>
<th>Measure</th>
<th>NQF #</th>
<th>Finalized Cross-Setting Measure</th>
<th>Payment Determination Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHSN Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure</td>
<td>#0138</td>
<td></td>
<td>FFY 2015 and beyond</td>
</tr>
<tr>
<td>NHSN Central Line-Associated Blood Stream Infection (CLABSI) Outcome Measure</td>
<td>#0139</td>
<td></td>
<td>FFY 2015 and beyond</td>
</tr>
<tr>
<td>Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay)</td>
<td>#0678</td>
<td>Yes</td>
<td>FFY 2018 and beyond</td>
</tr>
<tr>
<td>Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay)</td>
<td>#0680</td>
<td></td>
<td>FFY 2016 and beyond</td>
</tr>
<tr>
<td>Influenza Vaccination Coverage among Healthcare Personnel</td>
<td>#0431</td>
<td></td>
<td>FFY 2016 and beyond</td>
</tr>
<tr>
<td>Measure</td>
<td>Code</td>
<td>Period</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
<td>----------------------</td>
<td></td>
</tr>
<tr>
<td>NHSN Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staphylococcus aureus (MRSA) Bacteremia Outcome Measure</td>
<td>#1716</td>
<td>FFY 2017 and beyond</td>
<td></td>
</tr>
<tr>
<td>NHSN Facility-Wide Inpatient Hospital-Onset Clostridium difficile</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection (CDI) Outcome Measure</td>
<td>#1717</td>
<td>FFY 2017 and beyond</td>
<td></td>
</tr>
<tr>
<td>All-cause Unplanned Readmission Measure for 30 Days Post-Discharge</td>
<td>#2512</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>from Long-Term Care Hospitals</td>
<td></td>
<td>FFY 2018 and beyond</td>
<td></td>
</tr>
<tr>
<td>Percent of Residents Experiencing One or More Falls with Major Injury</td>
<td>#0674</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>(Long-Stay)</td>
<td></td>
<td>FFY 2018 and beyond</td>
<td></td>
</tr>
<tr>
<td>Percent of LTCH Patients with an Admission and Discharge Functional</td>
<td>#2631</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Assessment and a Care Plan That Addresses Function</td>
<td></td>
<td>FFY 2018 and beyond</td>
<td></td>
</tr>
<tr>
<td>Change in Mobility among Patients Requiring Ventilator Support</td>
<td>#2632</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>FFY 2018 and beyond</td>
<td></td>
</tr>
<tr>
<td>NHSN Ventilator-Associated Event (VAE) Outcome Measure</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>FFY 2018 and beyond</td>
<td></td>
</tr>
</tbody>
</table>

To meet the requirements of the IMPACT Act, CMS is finalizing three new measures for inclusion in the QRP. These three measures are all claims-based and cross-setting measures for FFY 2018 payment determination and subsequent years. They are:

- Medicare Spend Per Beneficiary (MSPB);
- Discharge to Community (which assesses successful discharge to the community including no unplanned re-hospitalizations and no deaths within 31 days following discharge from the LTCH), and
- Potentially Preventable 30-Day Post-Discharge Readmissions.

A fourth measure, one that is assessment-based and is for the FFY 2020 LTCH QRP, is a drug regimen review conducted with follow-up for identified issues measure which assesses whether PAC providers were responsive to potential or actual clinically significant medication issue(s). Data collection would begin April 1, 2018.

CMS is finalizing its proposal to add 4 new measures to LTCH QRP public reporting by the Fall of 2017 on Hospital Compare. CMS clarified the previously finalized review and correction periods for LTCH QRP public reporting and emphasizes its alignment with the Hospital IQR Program’s policies and procedures.

In the proposed rule, CMS sought comments on LTCH QRP quality measures under consideration for future years. These measures are: Transfer of health information and care preferences when an individual transitions; Patient Experience of Care; Percent of Patients with Moderate to Severe Pain; Advance Care Plan; Ventilator Weaning (Liberation) Rate; Compliance with Spontaneous Breathing Trial (SBT) (including Tracheostomy Collar Trial (TCT) or Continuous Positive Airway Pressure (CPAP) Breathing Trial) by Day 2 of the LTCH Stay; Patients Who Received an Antipsychotic Medication; and Venous Thromboembolism Prophylaxis.

**Interim Final Rule**

*DISPLAY pages 1280 - 1283*

Within the FFY 2017 IPPS/LTCH PPS final rule, CMS finalized an Interim Final Rule to implement section 231 of the Consolidated Appropriations Act of 2016 that establishes a temporary exception for certain wound care discharges from the site-neutral payment rate for certain LTCHs. In the rule, CMS establishes that rural LTCHs that “participated in Medicare as an LTCH and was co-located with another hospital as of September 30, 1995, that currently meets the requirements of section 412.22(f) of the Social Security Act” qualify for the relief. Section 412.22(f) defines “qualified LTCHs”.

This relief applies to patients who received treatment in the LTCH for “severe wound” cases and were discharged prior to January 1, 2017. Because the legislative criterion describing severe wounds does not match ICD-10 guidelines, CMS is establishing unique definitions for qualifying cases. The following qualify as “severe wound” cases:

- “wounds with morbid obesity,” which are wounds in those with morbid obesity that require complex, continuing care local wound care occurring multiple times a day; and
- “infected wounds,” which require complex, continuing local wound care occurring multiple times a day.

CMS will use “payer-only condition codes” and LTCHs will have to flag these cases for their Medicare Administrative Contractors to receive a code on the claim, which will result in an LTCH PPS payment rather than a site neutral payment.

The interim final rule also amends current regulations to allow hospitals to reclassify based on their acquired rural status, effective with reclassifications beginning with FFY 2018. This allows such hospitals to use the distance and average hourly wage criteria designated for rural hospitals. In addition, a hospital that has an active Medicare Geographic Classification Review Board (MGCRB) reclassification that is approved for a rural redesignation will be allowed to maintain both classifications simultaneously. Such hospitals would receive a reclassified urban wage index, and would also continue to be considered rural for all other purposes.

Hospitals reclassified in this way will be included in the calculation of the state rural wage index, if including wage data for hospitals with rural reclassifications raises the state’s rural floor. These hospitals will also be included in both the wage index calculation of their home CBSA, as well as that for the reclassification wage index of the MGCRB reclassified CBSA. However, CMS states that these hospitals will be excluded from the calculation of a state’s reclassified rural wage index.

Hospitals with an existing MGCRB reclassification would also have the opportunity to seek rural reclassification for IPPS payment and other purposes and keep their existing MGCRB reclassification.

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